Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #23 PART I, PER HHY G791 I-20-01 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth Month **Physician** Robert K. Dore December 20, 2000 0210 /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery 8. Dale of Birth (Month, Day, Year) If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** 180 M 2□ F Months Deys Hours Min Yrs. 217-46-6670 75 June 6, 1925 **Director** Massachusetts Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☒ No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 13517 Oriental Street items 23s 20853 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Meritel Stetus hours efter 1 Yes 2 No
If Yes, Give
Year or Dates: WWII 1 Never Married 2 N Married Maryland 21215-0020 ò 1 ☐ Yes 2 ☒ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 72 oe filed within 7 ai Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Security Officer Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) 12 should be fit h end Mentai H is merked ott Edmund Dore Adelaide Kennedy 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) itam 27 is Victoria E. Dore/Wife 13517 Oriental Street, Rockville, Maryland 20853 other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Silver Spring, Pages of Department of Important: If it any injury or o December 1 Buriel 2 □ Cremation 3 □ Removel from State Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Gate of Heaven Cemetery 23, 2000 22. Name and Address of Fecility Robert A. Pumphrey Funeral Home/ 21. Signature of Funeral Servica Licensee Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 MO1126 23a. Pert1. Enter the disease, or comptications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line HHDATO HILLIAM CARCINOMA Approximete Intervel Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) edical Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last burial-tran Due to (or es e consequença of) pue Box 68760. physician certificate be edicai the t Due to (or as e consequence of) 98 attending p Physician/M 23b. Did tobacco usa contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. the deteched signed by t 2 No 3 Probably 4 Unknown 1 Yes Records, þ 24b. Were autopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed peen s certificata hes page 2 1 Yes 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Hopatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Yes 2 No 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how Injury occurred Certification: 28b. Time of 28c. injury at Work? After Division Attending 5 Pending death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendiff within 24 hours aftar death. To the Funeral Director: All completely filled in by that fu 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d, Date signed (Month, Dev. Year) 29b. Signature end the of or 5+1 30. Name end eddress of party (Item 23a) una 31. Dete filed (Month, Day, Year) State **DEC 22** Registrar

DHMH 16 Rev 6/95



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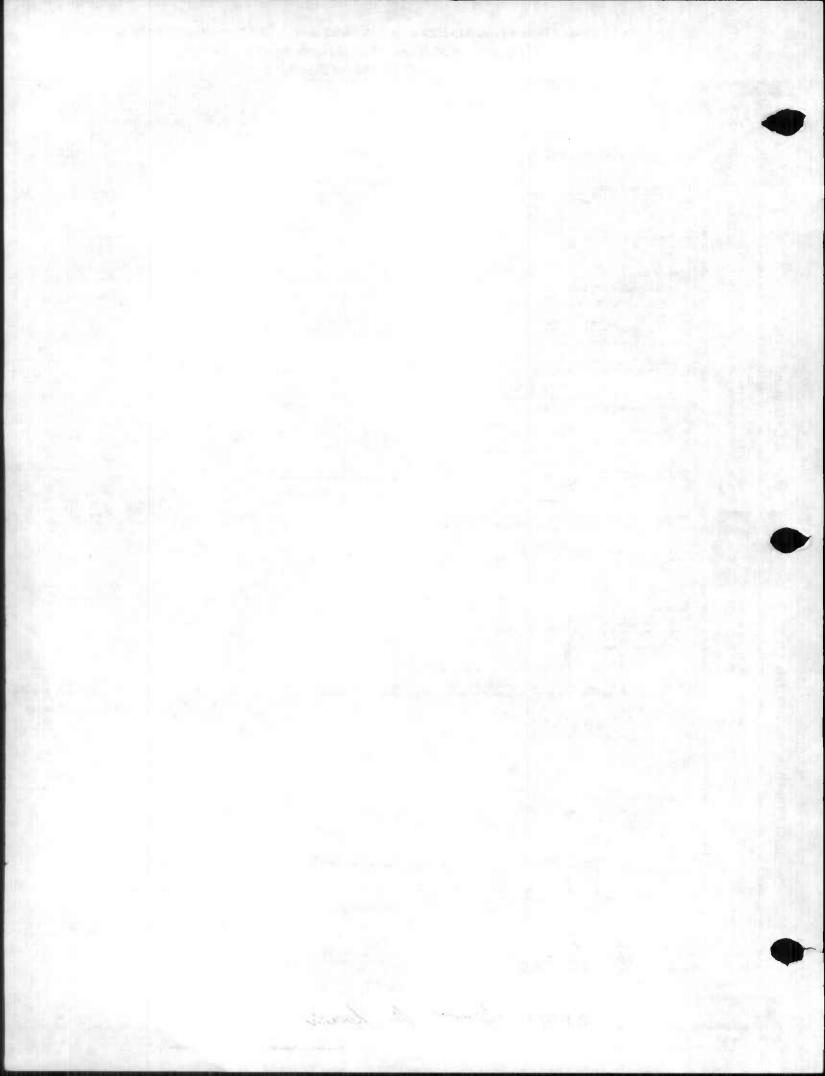
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day 30 Month Year **Physician** Maggie Fisher December 2000 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Undar 1 Yaar | If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) April 15, 1913 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 280 F 220-03-5335 87 **Director** MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r 28a-f ahow 10d. Inside City Limits 1 XYes 2 No Director MD Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or flems 23s or 4306 Tower Drive 21863 U.S. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puarto Rican, atc.) 14. Race - Amarican Indian. 11 Marital Status Black, White, atc. filed within 72 hours after 1 Nevar Married 2 Married Yes 20 No 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black by 3 □Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hyglene. Laborer Farming 4th Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) . Peges 1 and 2 should be file ment of Heelth and Mental Hi lant: If item 27 is marked oth jury or other traumatic even Harry Foreman, Sr. Emma Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Corbin/granddaughter 4306 Tower Drive, Snow Hill, MD 21863 Baltimore, 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Pege Department Important: If any injury or 4 □ Donation 5 □ Other (Specify) Williams AME Church Cem 1/6/2001 Newark, MD 21. Signature of Funeral Services promises 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) myscardial moments tarction Examiner Due to (or as a consequence of) Examine CAD use as the burial-tren Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pug Due to (or as a consequenca of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Medical Certification: To Be Completed pege 2 certificate has 1 Yes 2 No 1 ☐ Yas 2 ☐ No in or Attending Physician: The state death.

Is after death.

In Director: After this certificate of in by the funeral director, pr of Vitai 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Dey Year) 28c. tnjury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation Injury 1 Yes 2 No 2 Accident 3 Suicida 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - Al home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of centle D 41721 mo 12/30/00 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) 10 Box 49, SAlisbury, MD 21803 M.D. phan 31. Data filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 0 4 2001

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended item#23 per MD FCHD, KS 1/16 Gartificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 23, December 2000 PERRY HALL 2:15 p.m. /Medical 4a Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Health Care Center Frederick
If Under 24 Hrs. Frederick If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** 1 M 2□ F Days Hours Yrs. 81 Director Pennsylvania 157-01-1470
Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. tnside City Limits itens. return!, or items 23a or 28a-l show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Frederick Monrovia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12507 Wolf Den Court 21770 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Detes: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married Married Maryland 21215-0020 Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind at Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 5+ Naval_officer U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be nd Mental is marked Hall, Jr. Alvah Lillie Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) important of Health as important if item 27 is a say injury or other i-once. Anne Gallagher / daughter 2389 Glover Dr., Mt. Airy, MD 21771 Baltimore, 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State Date 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 12/26/00 Hagerstown, MD 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee Jarquelen 8 E. Ridgeville Blvd, Mt. Airy, MD 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death)Physician /Medical Immediate Cause (Finel disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Examiner Hypertension The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequenca ot): pue Box 68760, After this certificate has been signed by the attending physicien funeral director, page 2 should be detached for use as the buria Atherosclerosis Physician/Medical that initieted events resulting in death) Last Due to (or as a consequence ot): P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy tindings evailable prior to completion of cause of death? 24a. Was an autopsy Completed 1 ☐ Yes 2 No 1 ☐ Yes 2 No Physician: Be 25. Was case reterred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P safter death.
I Director: After to in by the funers 1 Netural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, tarm, street, tactory, offica building, etc. (Specify) 28t. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

I medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29e. Certifier

State Registrar

31. Date tiled (Month, Day, Year) 32. Registrar's Signature DEC 2 6 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and little of certifier

end menner steted.

Dr. Nancy S. Thompson , 172 Thomas Johnson Dr., Suite 202, Frederick, MD 21701

0055995

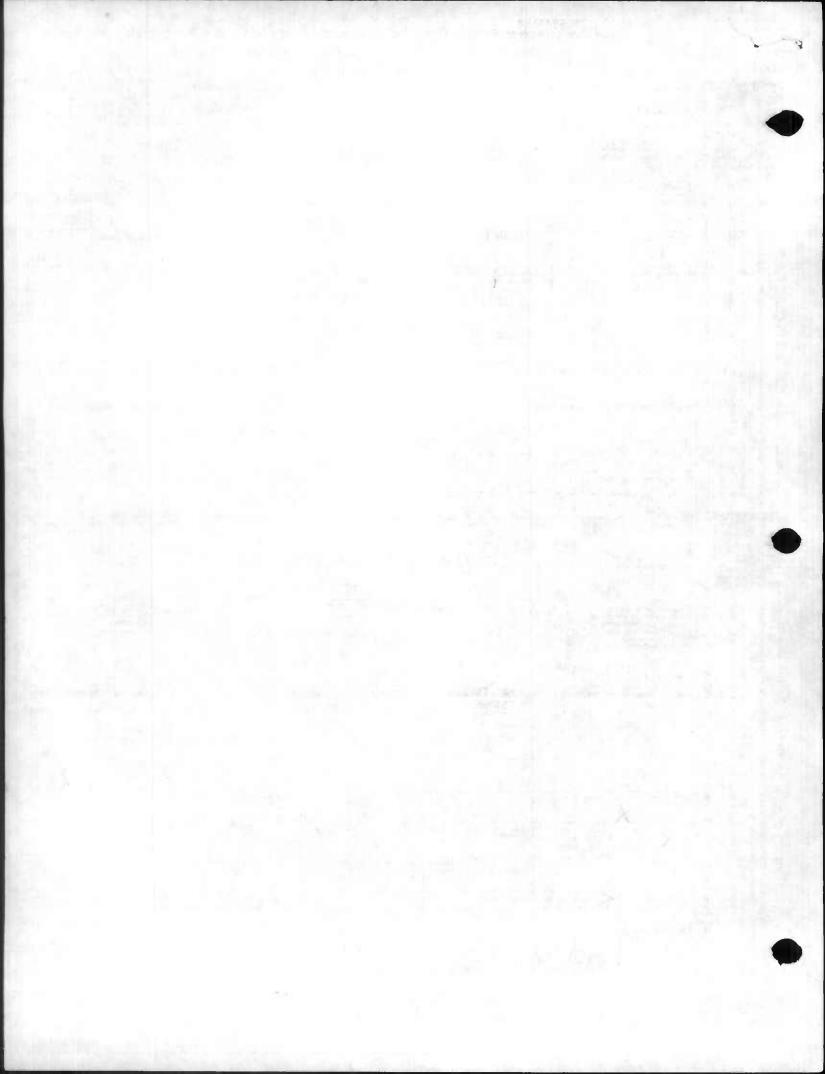
29d. Date signed (Month, Day, Year)

000S

29c. License number

\$

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AMEND ITEMS: #27,28A-F PER PHY MEO G792 2-26-01 WR. Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene. AMEND ITEM: #23 PART I PER PHY G791 1-20-01 WR. Certificate of Death 1 Decedent's Nama (First Middle Last) 2 Data of Death 3. Time of Death Month Physician 2000 Dec. 1 2055 HALLE BERWELL HERSHBERGER /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Oakland Garrett Co. Mem. Hospital If Undar 1 Yaar | If Undar 24 Hrs Birthplace (Stata or Foraign Country) 5. Social Security Number 7. Aga (in yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** 12 M 2□ F Days Hours Yrs. 213-01-6601 Director Dec 21 1912 WVa 27 Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 □ No Md Garrett Oakland Directo 10a. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 8 238 USA Funeral 1100 Mary Dr 21550 12. Was Decedant Evar in U.S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc. I ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 1 ☐ Nevar Married 2 ☐ Married 8 1 ☐ Yas 2 ☐ No Specify: à 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Iron City Tube & Metal 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Marrial I Della May Streets Harry Hershberger 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) Salth m 27 21550 Mildred Deanna Porter 5638 Hutton Rd. Oakland, Md 20b. Place of Disposition (Nema of camatary, crametory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Pages 1 Burial 2 ☐ Cramation 3 ☐ Removal from Stala Kalbaugh Cemetery Dec 4 2000 Elk Garden WV 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama end Addrass of Facility David A. Burdock Funeral Home 710 Church St. Kitzmiller, Md 21538 23a. Part / Entar the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death Vermone Immediata Causa (Final disaasa or condition rasulting in death) Examir Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events Physician/Medical that initieted events rasulting in death) Last Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 2 KNO DEMENTIA, OSTEOPOROSIS, CHRONIC GASTROINTESTINAL BLEEDS 1 Yes 3 Probably 4 ☐ Unknown 24b. Ware autopsy findings available prior to complation of ceuse of daath? 24a. Was an autopsy Completed performed? 2 KINO 1 ☐ Yas 2 ☐ No 1 Yas 89 26. Plece of Deeth (Check only one) To

Physician /Medical Examiner

21215-0020

Maryland

Baltimore,

25. Was case retarred to medical axaminar?

1 Ayas 2 900 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 28d. Dascribe how injury occurred

27. Manner of Death 1 Natural 2XXAccidant 3 Suicide

4 T Homlcide

29e. Certifier

Certification:

edical

State Registrar

28a. Dete of Injury (Month, Dey Year) 11-28-2000 5 Panding invastigation 6 Could not be determined

28b. Tima of P 10:00 1 Yas 2 No

SUBJECT FELL IN HIS ROOM

28a. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) NIIDCTNC HOME NURSING HOME

281. Location (Street and Number or Rwal Route Number. City or Town, Stata) 1113 MARY DRIVE

OAKLAND, MARYLAND

29b. Signature(and tale of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licansa number 29d. Data signad (Month, Day, Year)

30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print) Memor 880

ue 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

DHMH 16 Rev 6/95

Division

after death

To the Hospital within 24 hours a To the Funeral C

b

ORIGINAL

Species of the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day **Physician** Byron (NMN) Israel AKA: Pete (NMN) Israel December 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Undar 1 Yaar | If Under 24 Hrs. 6. Sex 1 M 2 □ F Birthplace (Stata or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months Yrs. Director Dec. 8, 1907 Indiana 011-10-9823 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Directo Maryland Frederick Frederick 10e Street and Number 10f. Zlp Code 10g. Citizen of What Country? must be r 419 Delaware Road 21701 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 No If Yes, Giva Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Black, White, etc. 1 Nevar Married 2 Married 1 Yes 2 No Specify "natural", or Specify: À 3 N Widowed 4 □ Divorced White Yaar or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Production Manager Eve Glass Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Jesse Israel Anna Long 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health a It if item 27 is or other tra Mary Ann Shindel, daughter 200 Rockwell Terrace, Frederick, MD 21701 20b. Placa of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 █ Burial 2 ☐ Cramation 3 ☐ Ramoval from State Olivet Cemetery 4 □ Donation 5 □ Other (Specify) Frederick, Maryland 22. Name and Address of Facility Keeney and Basford Funeral Home 21, Signature of Fugural Service Licenses 2000 M00999 21701 106 East Church Street, Frederick, MD 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he art failure. List only one ceuse on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final SEPSIS disease or condition rasulting in death) WEEM Examiner Due to (or as a consequenca of) 14000 (1 NFERTION Examin physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) de me de Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequence of): for use as Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part 23b. Did tobacco use contribute to the cause of death? signed by t 1 | Yes 2 | No 3 | Probably 4 | Junknown Ulmorals by 24b. Were autopsy tindings available prior to been si Completed 24a. Was an autopsy completion of cause of death? page 2 1 Yas 2 No PAVENTONIA Division of Vital 25. Was casa referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death or Attending 5 Pending investigation 1 Natural fell in. N. H 10:00 PM mo death. 1 Yes 2 No 190 16 Director: / 2 Accident 2000 28f. Location (Street and Number or Rural Route Number, City by Town, State)

200 E. 16 L. T. FREDERICA AD. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide FREDERICA NORTHAMPTON MANOR NONSING HOME 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier

To the Hospital o within 24 hours af To the Funeral Di completely filled in

Ö

29b. Signature and title of certifier

(Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

D35164 Dec 26, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

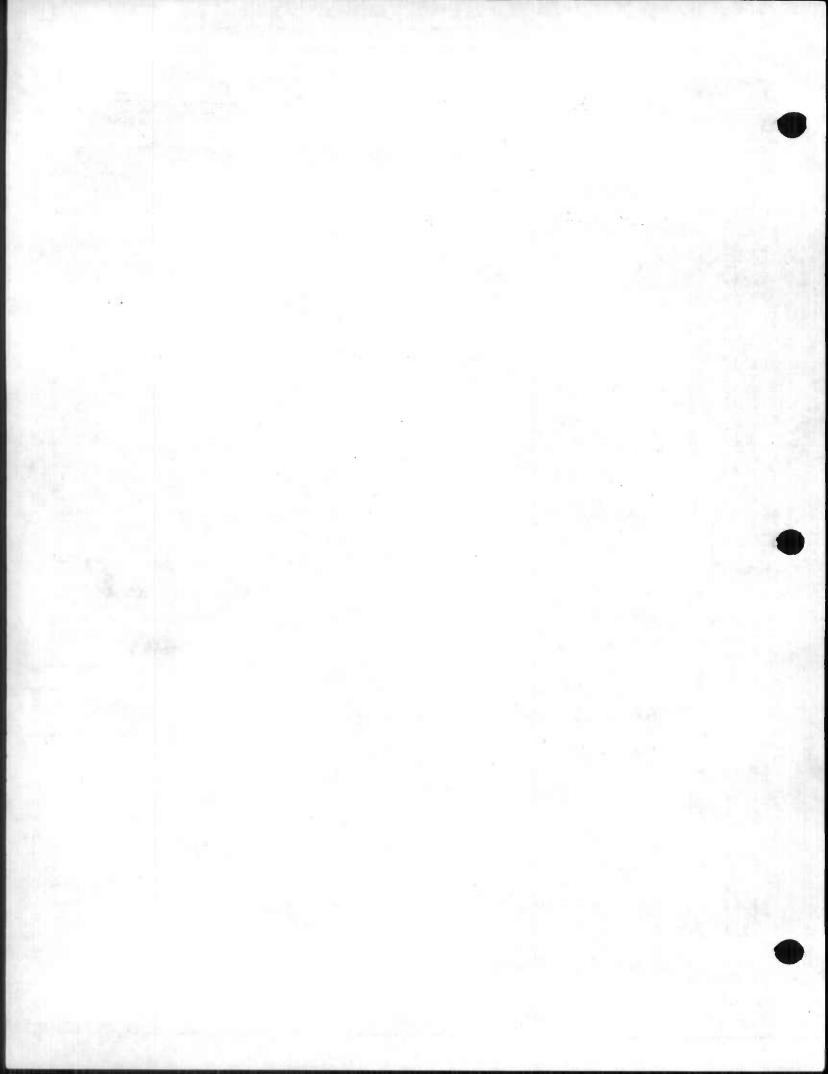
Andrew Zarick, Jr, M.D., 1080 West Patrick Street, Frederick, Maryland 21703 31. Data filed (Month, Day, Year)

State Registrar

UEC 2 6 2000







Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Yaer Month **Physician** C. 11:05 PM 2000 ALOOTHA Jones 22 /Medical 4b. City, Town, or Location of Death 4e Fecility Name (If not Institution, give street end number) 4c. County of Deeth City, ...

Bally mure

If Under 24 Hrs. 8. Dete of Birth
(Month, Dey, Year)

12 -23 -3 Examiner of Maryland Medical System BALLIMORE CO. If Under 1 Yeer Months Deys Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 6. Sex **Funeral** Deys 19M 2DF 217-30-9095 Director 1 Usual Residence of Deceden the Maryland 10c. City, Town or Location 10e. Stete 10b. County 10d. tnslde City Limits r is marked other than "natural", or flems 23a or 28a-f show trsumstic event, the Medical Examinar must be notified at 1 Yes 2 No KEM7 Director mo WorTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 306 ROSEYELF USA 21620 Funeral 72 hours after death 12. Was Decedent Ever in U,S.
Armed Forces?
1 Yes 2 Who
If Yes, Give
Yeer or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Meritel Status Bleck, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: Black py 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Etementary/Secondary (0-12) Cotlege (1-4or 5+) Hygiene. Dros, Coust. CONSTRUCTION TALLEY 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other treumatic event page. Be KEUBEN JONES MATIAH WILSON 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) BARBARA E. JONES-DAUGHTER 306 ROOYELT Dr. CHESTER TOWN, and 21620 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from State 12.28.00 CHESTER TOWN 4 ☐ Donetion 5 ☐ Other (Specify) JAMES UM CHURCH CEM. 21. Signature of Funerel Service Licensee 22. Neme end Address of Facility P.O. Box 88 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart bailure. List only one cause on each line. WALLY AUNERAL SERVICE CHESTER town 4 md. 216020 Approximete tntervet Between Onset end Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Collapse Cardio pulminary Examiner Due to (or es a consequence of): Physician/Medical Examiner SEPSIS ate has been signed by the ettending physician and page 2 should be detached for use as the buriel-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es a consequence of): Box 68760, Sacral Wound Infection thet initieted events resulting in death) Lest Due to (or es e consequence of): The law requires that the deeth Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown UREMIA Division of Vitai Records. p 24b. Wera autopsy findings evailable prior to completion of cause of deeth? 24a. Wes en sutopsy performed? Completed End Stage Renal Disease 2 No t Yes 20 No 1 Yes To the Hospital or Attending Physician: The within 24 hours after death.

To the Funersi Director: After this carificate i completaly filled in by the funeral director, pag 25. Wes case referred to medical axaminer? 8 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

| Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. Medical 29a Certifier 29d. Date signed (Month. Day, Year) 29b. Signeture end title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 2439 12-22-2000 31. Date filed (Month, Day, Year)
DEC 2 7 200 Atiemo Maryland Medical System University 32. Registar's Signature State 7 2000

Registrar **DHMH 16 Rev 6/95**

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent'e Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey **Physician** 18, 2000 HELEN T. MUNGER

4a Fecility Name (If not institution, give street and number) Dec. 7 pm /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 25935 Worton Lynch Road Worton Kent 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 25 F Yrs. 97 Director 091-28-1475 Oct 24 1903 Maryland Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Nema 23s or 28s-f show any Injury or other treumatic event, the Wedge Hampfret must be notified at once. 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Kent Worton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25935 Worton Lynch Rd 21678 U.S.A. Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Dates: 14. Rece - American Indian, 11. Meritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 3 No Specify: Specify: White à 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Cotlege (1-4or 5+) Elementery/Secondery (0-12) telephone operator telephone company 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Ida Lee Walker Henry E. Taylor 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Charles Joiner Jr. (nephew) 25935 Worton Lynch Rd. Worton, MD 21678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Kent Cremation Serv. 12/19/00 4 □ Dongtion 5 □ Other (Specify) Smyrna, DE 21. Signature of Funeral Service Licensels 22. Neme and Address of Fecility Galena Funeral Home of Stephen L. Schaech MOUS 10 118 W. Cross St. Galena, MD21635

List only one cause on each line.

MOUS 10 118 W. Cross St. Galena, MD21635

Again to the death of the dea Approximate Intervel Between Onset and Death Physician /Medical Immediete Cause (Finel diseese or condition resulting in deeth) Examiner Due to (or es a consequence of): Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Box 68760. Physician/Medical Due to (or es a consequence of): USB ed by the a Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? P.O. alpheiners Disease signed by t 1 Yas 2 No 3 Probably 4 Unknown Records. à Ca 4 Rt Breast 24a. Wes en autopsy performed? 24b. Were eutopsy findings aveilable prior to Completed completion of cause of death? 1□ Yes 20 No 1 ☐ Yes 2 ☐ No of Vital 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only gne) Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this ar death. funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 (Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Attending 5 Pending investigation 1 Yes 2 No e Hospital or Attendi n 24 hours after death e Funerel Director: A 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) à 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. edicai 29a. Certifier (Check only one) To the To the F 29c. License number 29d. Date signed (Month, Dey, Year) (Clery ars. 12/19/00 D 21313 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Kin K. Wun 31. Dete filed (Month, Day, Year) 415 Washington Ave. Chestertown, MD 21620

State Registrar

DHMH 16 Ray 6/95

32. Registrar's Signature

DEC 2 0 2000

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 4 3509

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 31, Day 2000 Month Physician Dec. Ruth Brown Monaghan 8:15 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park

If Under 24 Hrs.
Min.

8. Date of Birth
(Month, Day, Year) Washington Adventist Hospital Montgomery If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 KF Months Days 92 Yrs. 215-54-5952 Director 19, 1908 Maryland Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mentel Hyglene. Important: if than 27 is marked other than "natural", or hams 23s or 28s-f show important: if than 27 is marked other than "natural", or hams 23s or 28s-f show important in the mortant and injury or other traumatic event, the Medical Examinations in page. 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2√ No Director Maryland Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20912 8314 Haddon Drive USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14 Race - American Indian 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 XNo Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) 1 2 College (1-4or 5+) Dental Receptionist Dental 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) James Dallas Brown Amalia Sophia Krah 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ruth C. Monaghan/Daughter 8314 Haddon Drive, Takoma Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State Jan. 9, 2001 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat'l Cemetery! 4 ☐ Donation 5 ☐ Other (Specify) Arlington, VA 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service Licensee lha 500 University Blvd., W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Hypernatremia 4 days Examiner Due to (or as e consequence of): Examiner Metabolic Encephalopathy 4 days or Attanding Physician: The law requires that the deeth certificate be executed physician and s the burial-trensit Sequentially list conditions, if any, leeding to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Cardiac Dysrhythmia 3 days Physician/Medical Due to (or as a consequence of): SI attending p Chronic Renal Failure 3 years signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2000 3 Probably 4 Unknown p 24b. Were autopsy findings been si 24a. Was an autopsy Completed performed? available prior to completion of cause of death? s certificate hes t 1 Yes 20 No 1 ☐ Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 27. Menner of Death 28d. Describe how injury occurred Certification: 28b. Time of 1 (XNatural 5 Pending deeth. 1 ☐ Yes 2 ☐ No Investigation 2 Accident rector: A 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide veral Dire To the Hospital o within 24 hours at To the Funeral D completely filled I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated.

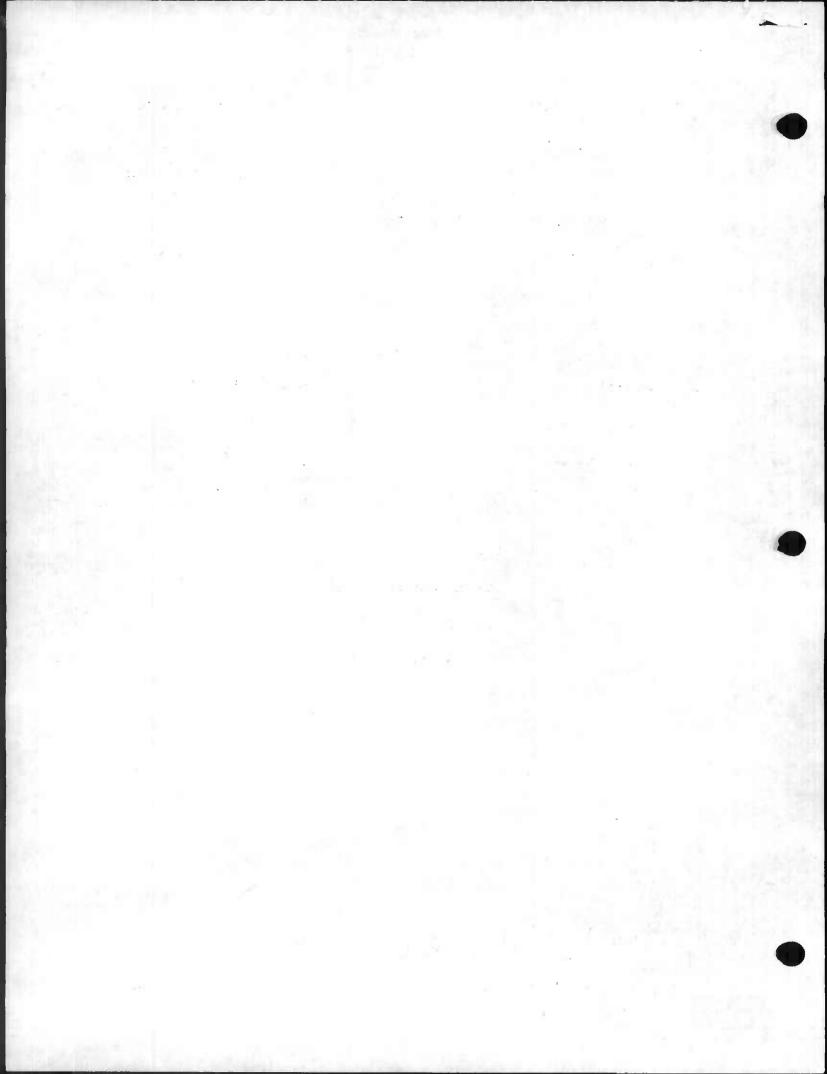
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edical 29a. Certifier 29b. Sign 29c. License number 29d. Date signed (Month, Day, Year) Munkay D-40201Jan. 9, 2001 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Farzad Assar 19251 Montgomery Village Ave., #F-24, Montgomery Village, MD 20886

State Registrar 31. Date filed (Month, Day, Year)

JAN 11 200

32. Registrar's Signature

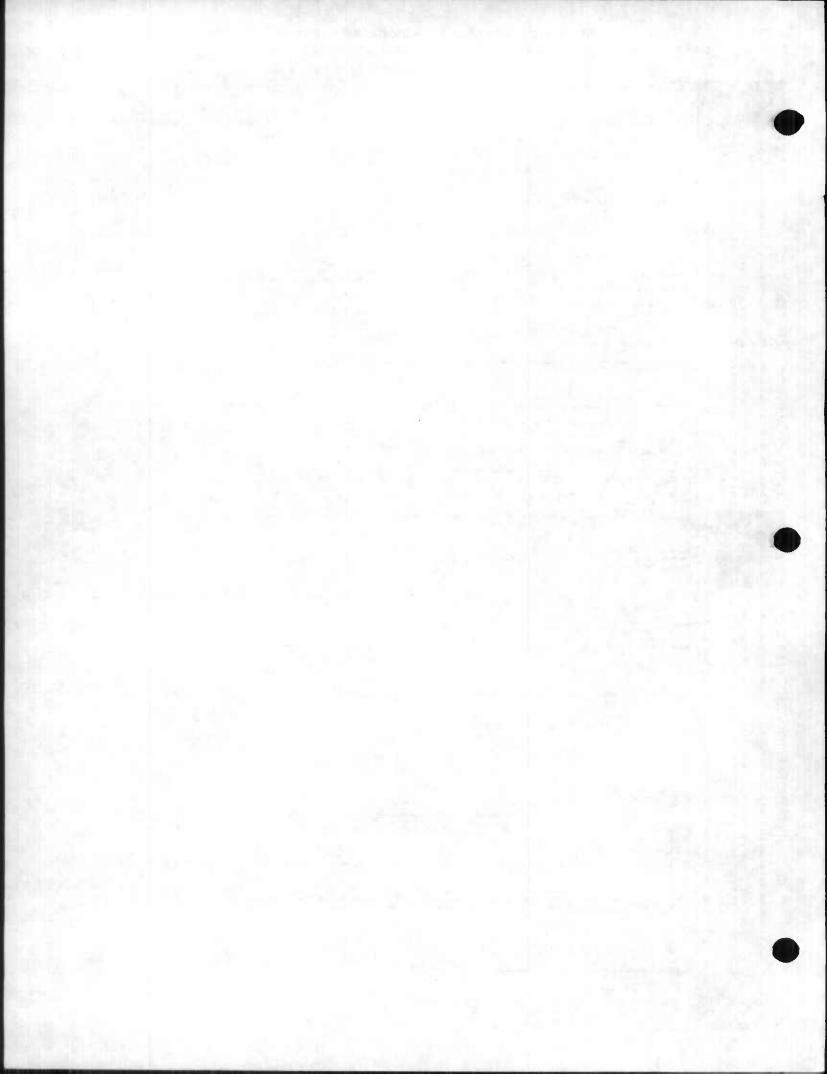
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	State of Maryland / Department of Health and Menta	l Hygiene	4351	-
	Certificate of Death	Reg No.		

				Ce	rtificate of	Death	Re	ig. No.			
		1. Decedent's Name (First, Middle, La	Day Year	3. Time of Death							
	Physician /Medical	Rosemoned D Myrose C					December		3:30 AM		
j	Examiner	4a Facility Name (If not institution, giv	e street end number)			4b. City, Town, o	Location of Death	4c. County of Death			
		7934 Yellow Sprin	0				erick	Freder			
	Funeral	5. Social Security Number 6. S	TOTAL OF E	s. last birthdey) Yrs.	Months Days		(Month, Dev.	Year) 9. Birth	nplace (State or Foreign intry)		
	Director	213-24-8051 Usual Residence of Decedent	70	U IIIs.			August	14,1930 V1	irginia		
	land and	10a. State 10b. County	10c. (City, Town or Le	ocation				10d. inside City Limits		
	Many Hed at	Maryland Frederic	ck	Frede	rick				1 ☐ Yes 2 ☑ No		
	or 28s-f i be notified	10e. Street and Number			10f. Zip Code	TA ALC: 1	10	g. Citizen of What Cou	untry?		
	h wit	7934 Yellow Sprin	ngs Road		217	02		United St	ates		
	ther death with the Marylar ribers 23e or 28e-f show liner must be notified at Furneral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U,S. 13.	Was Decedent of	Hispanic Origin? (Specify Yes or No- rto Rican, etc.)	14. Raca - Ameri Black, White			
Maryland 21215-0020	Mr. or		1 X Yes 2 No If Yes, Give Year or Dates:		1□Yes 2⊠No				hite		
5-0	"neturn edical	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occu	pation during most of w	orkina 1	16b. Kind of Business/Ir	ndustry		
21	Notice within Notice of the Man 'ser than 'ser	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire						
12		8 17. Father's Name (First, Middle, Last)		Owne	r/Operat		eme (First, Middle, M	Radiator R	lepair		
and	id the fi							alder Somemey			
Z	d Mer d Mer marks matic	Boate Guy Myers 19a. Informant's Name/Relationship (Type Print)	19h Maili	na Address (Stree		e Storall	City or Town, Stete, Zi	in Code)		
Ma	17 is 17 is 18 is	Freda E. Myers /	27						land 21702		
re,	THE STATE	20a. Method of Disposition			osition (Neme of matory or other ple			20c. Location - City or T			
mo	Page mi: #	1 XBurial 2 Cremation 3 4 Donation 5 Other (Specif	TUGILIONAL HOILI STATE		1 Cemete		Jan 4 2001 Wo	oodsboro, M	Marvland		
Baltimore	mit.	21. Signature of Foheral Service Licer			2. Name and Addr	4 50 100		Funeral Hom			
B	FULLE			16	21 Oposs				land 21702		
		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de	ath. Do not en	ter the mode of dy	ing, such as cardi	ac or respiratory arre	st,	Approximate Interval Between		
	Physician		11		. 1				Onset and Death		
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a 11/0(Card	ral 15	chemic	1		hours		
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2	executed in and inal-transit		b. LUNC	y Ca	neer				mouths		
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	he at he at red fo	Part il. Other eignificant conditions o	contributing to death but not re	esulting in the u	inderlying cause g	iven in Part I.	23b. Did to	pacco use contribute	to the cause of death?		
P.0	ed by the detache						LOY	1 Yes 2 No 3 Probably 4 Unknow			
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Records,	hou hou						perform	ned? a	vailable prior to completion of cause		
Rec	has has								of death?		
	certificate ha						1 ☐ Ye		Yes 2 No		
5		25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	☐ ER/Outpatie	a 20 004 0	ther:	eeth (Check only on	nca 8 Other (Spec	nife)		
of		27. Menner of Deeth	1 Inpatient 2 28a. Date of Injury (Month, Dey Year)				7	w injury occurred	ary)		
ion	ath. e fun	1 Natural 5 ☐ Pending 2 ☐ Accident investigation									
Division of Vital	tal or Attanding Pressive al Director: After the do in by the funeral Certification:	3 Suicide 6 Could not b		home, farm, st	reet, factory, office)	28f. Location (Str City or Town	reet end Number or Ru. s. Stete)	ral Route Number,		
	Cer Cer			,,							
	To the Hospital or Attanding Physicia. 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral Medical Certification:		nysician: To the best of my kr niner: On the besis of examinend menner stated.								
	Withi Vota	29b. Signal and tule of cartifier				nse number	L 25	9d. Date signed (Month			
		I HEGI	an, 15th			+4161	7	1-3-0	1		
		30. Name end address of person who	completed cause of death (Its	em 23e) (Type	FR FNC	RICK M	102170	01			
	Ctot	31. Date filed (Month, Dey, Year)	32. Registrar's Sig								
	State Registrar			va	5 6	me the					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 20, 2000 December 4c. County of Deeth

1. Decedent's Nema (First, Middle, Last) **Physician** Margaret Gertrude Gibbs Pullum /Medical 4a. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth Examiner Queen Anne's Corsica Hills Nursing Home Centreville If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Min. 8. Dete of Birth Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Yrs Director 196-18-9244 91 August 26, 1909 Usual Rasidence of Dacedant permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene.
Important: If item 27 is merked other tran "natural", or items 23s or 28s-f show any Injury or other traumatic event, or Heldick. 10a. Stata 10c. City, Town or Location Director Maryland Queen Anne's Chestertown 10e. Streat end Number 10f. Zip Code 10g. Citizan of Whet Country? 205 Old Bridge Road 21620 United States Funeral 12. Wes Decedant Ever in U,S. Armed Forces? 11. Menitel Stetus 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 14. Race - Amarican Indien. I ☐ Yas 2X No If Yes, Giva 1 Navar Merried 2 Married 1 ☐ Yas 2 No py specify: Black 3 Widowed 4 Divorced Yaar or Detes: Completed 16a. Decedant's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collaga (1-4or 5+) Cook Food Industry 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Surnama) Be 2 Samuel T. Gibbs Eleanora Virginia Wright 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
Queen Anne's Department of Aging
104 Powell Street, Centreville, Maryland 21617
ace of Disposition (Nama of page)

Dete 20c. Location - City or Town, Stata 19a. Informant's Name/Ralationship (Type, Print) Linda Carney- Guardian 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 1 XBurial 2 Cremetion 3 Ramovel from State Roseville Cemetery December 27, 2000 Price, Maryland 4 Donation 5 Othar (Specify) 21. Signatura of Funeral Sery 22. Nama and Addrass of Facility
Fellows, Helfenbein & Newnam Funeral Home, P.A X WIIIIam L. King, Jr. 1600337 370 Cypress Street, Millington, Maryland 21651

23a. Part. Enter the disease, or complication, the caused the death shock, or heart failure. List only one technical mode of dying, such as cardiec or respiratory arrast,

Approximate **Physician** /Medical Immediate Causa (Final diseasa or condition rasulting in daath) DENOCARA IN OMF Examiner Dua to (or as a consequence of) Examiner The law requires that the death certificate be executed

the attanding physician and hed for use as the burial-transit Physician/Medical been signed by þ Completed cartificate has director Be 10 Director: Aftar this d in by the funeral di Certification:

Division of Vital Records, P.O. Box 68760,

or Attending Physician:

Hospital

daath.

Vithin 24 hours after un To the Funeral Direct

Sequantially list conditions, if eny, leeding to Immadiate cause. Enter Undarlying Causa (Disaasa or Injury that initiated evants rasulting in daath) Last

Due to (or as a consaquance of) Dua to (or as a consequence of):

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I.

EMENTER HRONIC OBSTRUCTORE PUL

23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

24e. Was an autopsy

24b. Wera eutopsy findings available prior to completion of cause of death? 1 Yas QUINO

3. Tima of Death

1718 hrs

Birthplace (Stata or Foreign Country)

10d. Inside City Limits 1 ☐ Yes 2 X No

Maryland

Biack, Whita, etc.

25. Was cesa rafarred to medical axaminar? Hospital: 1 Yas 2 No

26. Piaca of Death (Check only one) Othar: 4 Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work?

28d. Dascribe how injury occurred

1 Yas

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

2 No

29a. Certifian (Check only one)

27. Manner of Death

1. Natural

2 Accident

3 ☐ Suicide

4 Homicida

12 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated.

29c. Licensa number

29b. Signature and title of certifie

5 Panding investigation

6 Could not be determined

1 Yas 2 No

29d. Date signed (Month, Clay, Year)

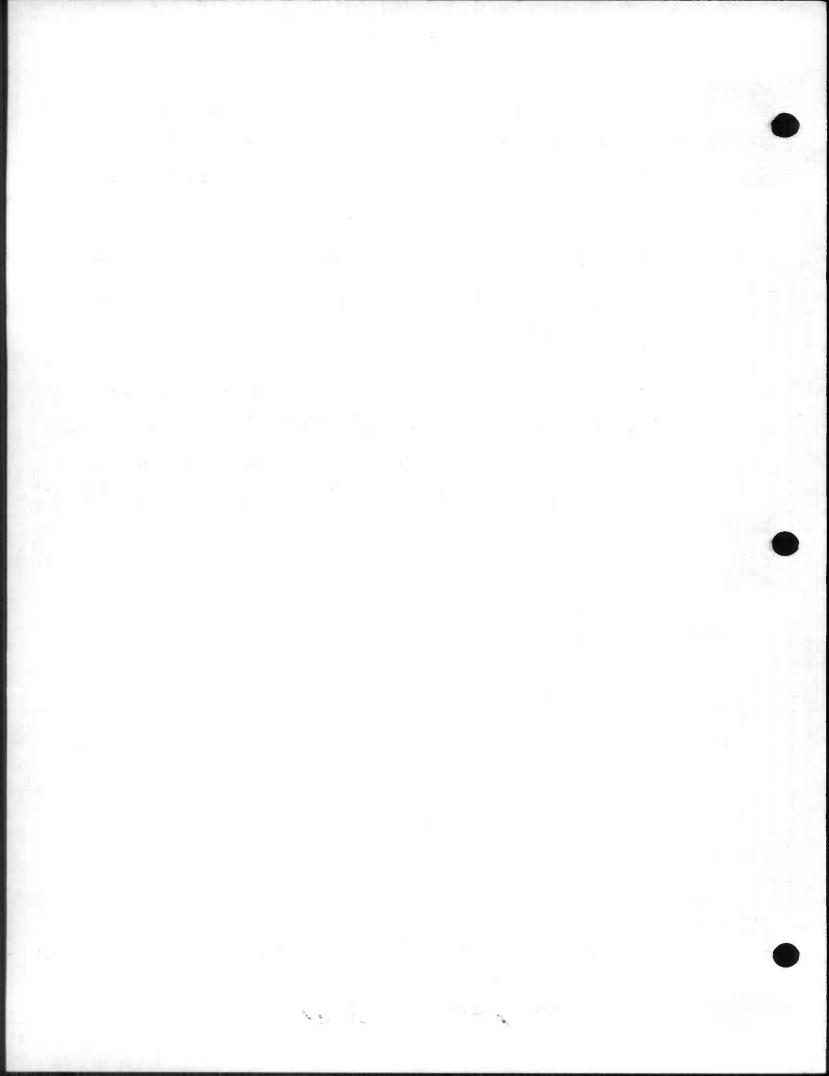
30. Name and address of gerson w daath (Item 23a) (Typa, Print)

2540 Eric Ciganek, M.D Centreville Rd. Centreville, MD. 21617

State Registrar

Medical

31. Deta filed (Month, Day, Year)
DEC 2 6 2000 32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1830 Sara Frances Peterson 30. December 2000 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Kent & Queen Anne's Hospital Chestertown
H Undar 24 Hrs. 8. Data 8. Data of Birth (Month, Day, Year) 5. Social Security Number If Undar 1 Yaar Birthplaca (State or Foreign Country) 6. Sax 7. Aga (In yrs. last birthday) **Funeral** 1□ M 21XF Months Days Hours Min 67 Yrs. 220-28-0363 January 24, 1933 Crumpton, Maryland Director Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 No Maryland Director Kent Chestertown "natural", or Herra 23s or 25s-f the Medical Examiner must be notifi-10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 133 Hillside Road Funeral 21620 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuben, Maxicen, Puerto Rican, etc.) 14. Raca - American Indien, 1 t. Meritel Status Black, Whita, atc. filed within 72 hours after 1 ☐ Yas 21☑ No If Yes, Giva △ Yaer or Detes: 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No py Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry then the Elementery/Secondery (0-12) College (1-4or 5+) Janitorial Cleaning Communications 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Surnama) Mental should be is marked Frank Reed Cora Teat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Coda) important: if item 27 is any Injury or other traun Pages 1 and 2 s nent of Health an Chris Peterson 129 Hillside Road, Chestertown, Maryland 21620 20b. Place of Disposition (Nama of camatery, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Data 1 XBurial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Chester Cemetery 1/5/2001 Chestertown, MD 21. Signetura of Funeral Sarvica Licensea 22. Nama and Addrass of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

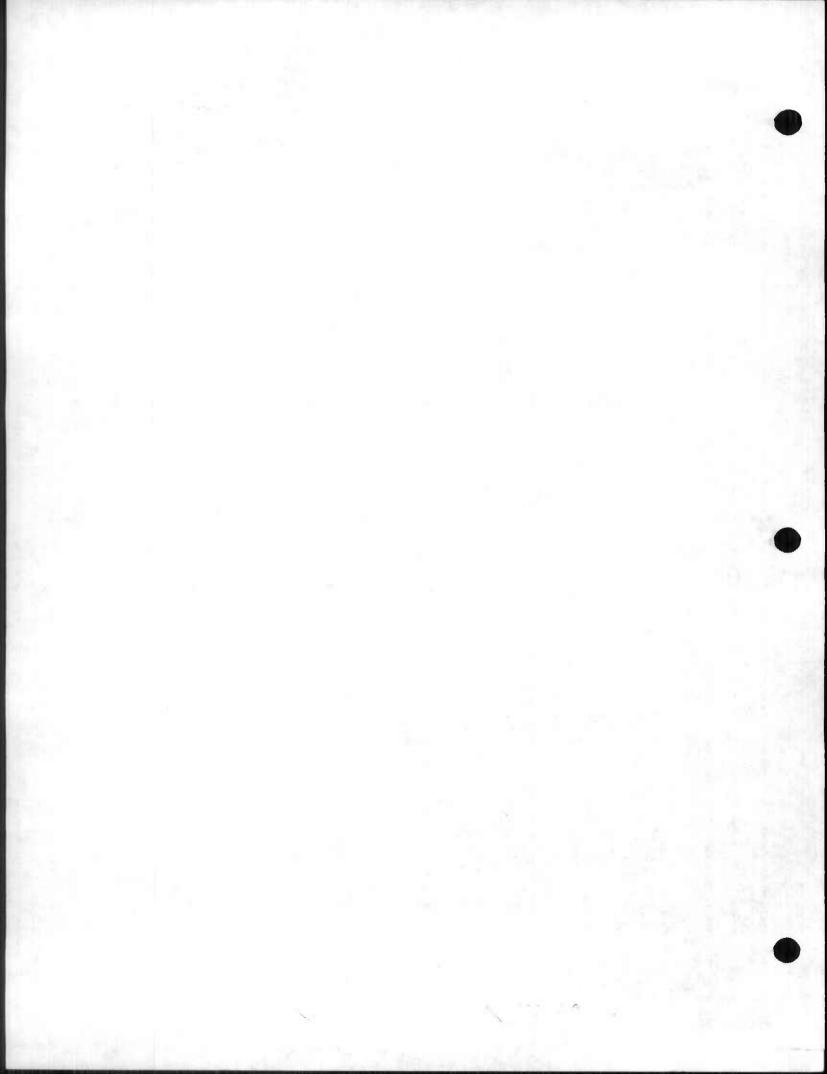
Approximate shock, or heart feilure. List only one cause on each line. tarvel Batween Physician /Medical Immediata Causa (Final OVASCO 99 disaase or condition rasulting in deeth) Examiner Dua to (or as a consequence of): Physician/Medical Examiner SSEM MAURS mass The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediata causa. Enter Underlying Causa (Disaasa or injury that initiated avanis resulting in death) Last use as the burial-tran Wee Box 68760. the attending physician 292 Due to (or es e consequança of) P.O. Pert II, Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the ceuea of death? ipital or Attending Physician: The law requires that the ours after death.

earl Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detact 200 No 3 Probably 4 Unknown 1 Yee Division of Vital Records. Be Completed by 24b. Wara autopsy findings eveilable prior to complation of causa of death? 24a. Was en autopsy performed? No 1 ☐ Yas 2 ☐ No 1 ☐ Yes 25. Was casa refarred to medical 26. Placa of Death (Check only ona) examinar? 1 Yas 2 No Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Menner of Death 28d. Dascribe how injury occurred Injury at Work? Netural 2 Accidant 5 Pending investigation 1 Yas 2 No 6 Could not be 28f. Location (Streat and Number or Rurel Route Number, City or Town, Stata) 3 Suicida 28a. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled. Certifying Physician: To tha best of my knowledga, deeth occurred at tha time, date end place, and dua Io lha causa(s) and mannar es stated.

Medical Examiner: On tha besis of examination end/or invastigation, in my opinion, death occurred at tha time, data and place, and dua to the cause(s) and menner stated. 29e. Cartifian 29d. Date signed (Month, Day, Year) 29b. Signature and titla of certifiag 29c. License numbe 15 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) Sen almin 31. Data filed (Month, DAN) 32. Ragistar's Signature

Registrar **DHMH 16 Rev 6/95**

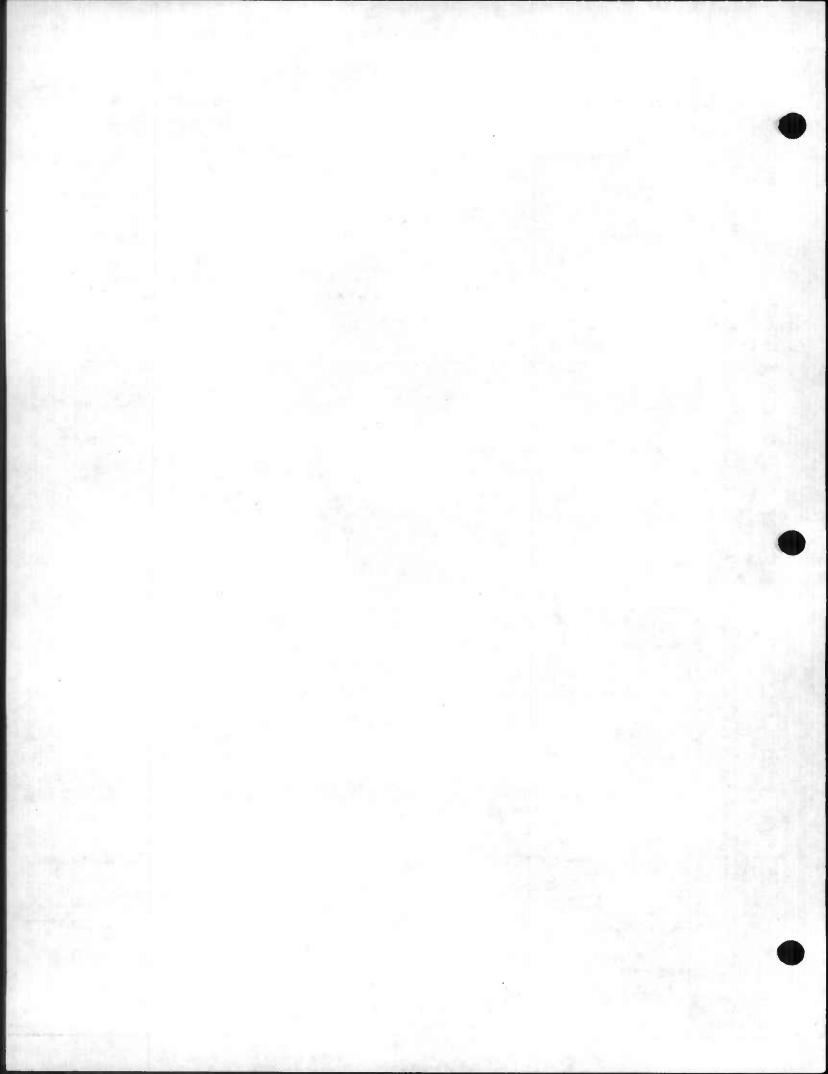
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiefiel 1, 3,5,1

	Decedent's Neme (First, M.	liddle (ast)		Cer	rtificate of	Death	2. Dete of De	Reg. No.		3. Time of Death
hysician	Mary Crimmor						Decem	ber 31,2	000	7:37 am
/Medical Examiner	4a Facility Name (If not Instit					4b. City, Town, or L	ocation of Deal	th 4c. County	of Deeth	
	Frederick Mem 5. Social Security Number	orial Hosp	ital 7. Age (In yrs.	last historias	If Under 1 Year	Frederic		Frede		loca (Ctata os Foreiga
rector	102-18-2703 Usual Residence of Deceden	1□ M 2□ F		76 Yrs.	Months Deys		8. Date of Bi (Month, D. 07-02-	1924	New	lece (Stete or Foreign try) York
No. W	10a. Stete 10b. Con	unty	10c. Cit	y, Town or Lo	cation				10	Od. Inside City Limits
otor	MD Fre	ederick	Fre	ederick						1 ☐ Yes 2,8€ No
Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Whet Coun	try?
erol erol	802 Dunbrooke		cedent Ever in U	e 13 v	2170		pacifu Vae or N		ited	States
st, or listne 23s or 28s-1 shore Examiner must be notified at by Funeral Director	11. Meritel Status 1 Never Merried 2風 3 Widowed 4 Divor	Armed F Merried 1 ☐ Yes If Yes, G	forces? 2 X No live		If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puerto Specify:	Rican, etc.)	Blac Specify	ck, White,	
retural, edical Exi		dent's Education phest grade completed,	1)	16e. Deced	dent's Usuel Occu	petion during most of worked)	kina	16b. Kind of Bu	usinass/Ind	dustry
t, the Medical Completed	Elementery/Secondery (0-1		/ (1-4or 5+)	Homem		ed)		0	wn Ho	vmo.
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To Be	unknown							Crimmins		nelly
-	19a. Informent's Name/Relet	ionship (Type, Print)		19b. Mailin	ng Address (Stree	t end Number or Ru				
1	Robert C. Re	ad/husband				Court, I	rederic			
	20a. Method of Disposition	on 3 Removel from	State 20b. P		sition (Neme of metory or other pla		L/4/01	20c. Location -		
	4 Donetion 5 Othe					h Cemeter		Clinton,	Mary	land
BUCS	21. Signeture of Funeral Sen	rice Licensee L 1C	reh	16	á-	ess of Fecility Sumtown Pi Maryland				
	23a. Pert1. Enter the diseese shock, or heert teilure.	e, or complications thet List only one cause on	caused the deet each line.	h. Do not ente	er the mode of dy	ing, such as cardiac	or respiretory	errest,		Approximate Interval Between
ian cal	tmmediate Cause (Final disease or condition		SERSU							10 doys
iner 🚡	resulting in deeth)	6.		or es e conseq	quence of):					
as the buriel-transit		b		REATIT					1	10 doss
Exan	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury		Due to (o	or as e conseq	quence of):				i	
edicai Examiner	that mitiated events	C	Due to /o	r es e conseq	uence of):					
	resulting in death) Last	d	23010 (0	. ee e eoriedq						
Physician/M							1			
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Completed by	ARTERIOSC	reutie (PARDIO.	- Vara	CULAR	DISEASE		s an autopsy formed?	ava	ere autopsy findings aileble prior to mpletion of cause death?
omp							1 🗆	Yes 2 No	10	Yes 2 No
BeC	25. Wes case referred to me examiner?	dical				26. Place of Dea	ath (Check only	one)		
Medical Certification: To Be Com	1 Yes 20 No			ER/Outpatien	IT 3LI DOA			sidence 6 🗆 Oth		y)
edical Certification:	27. Manner of Death 1 PNatural 5 Pending (Month, Dey Year) 2 Accident Status 22 Dete of Injury 28b. Time of Injury 28c. Injury et Work? 1 Yes 2 No						28d. Describe how injury occurred			
Certific	3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide		ce of Injury - At he ding, etc. (Specif		reet, factory, office			(Street and Numb own, Stete)	per or Rura	al Route Number,
edicai		fying Phyelcian: To the cal Examiner: On the band mei								
W comp	29b. Signeture end title of ce	tifier	4		29c. Licen	ise number		29d. Dete signe	d (Month,	Day, Year)
	Siran 1	James .	M.0	VPhi	n DI	0587		102	10	1
- 3	30. Neme end address of per	son who completed cau				FR	80881a	high.	Hos	ρ.
0	31. Date filed (Month, Dey, Y	ShITTI M	Registrates Signa		1500 AFF	APRI (-	REDEAM	(M)	24	701
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Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Deta of Death 3. Time of Death Day Month Yaai **Physician** Anna Attix Stevens December 26, 2000 0410 AM /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Millington K If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 369 Hurtt Avenue (At Home) Kent If Undar 1 Yeer Birthplace (State or Foreign Country) 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2 XX 83 Yrs. Director December 3, 1917 222-05-4675 Delaware Usual Rasidance of Decedent the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 ☐ No Directo Maryland Millington 10f. Zp Coda Kent 10g. Citizan of What Country? 10e. Street end Number deeth with 369 Hurtt Avenue 21651 United States Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Rece - Amarican Indian Black, White, atc. 12. Was Decedant Evar in U,S. Armad Forcas? 11. Maritel Status filed within 72 hours efter 1 Yas 2000 No 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2√No Specify: Specify: p ₩idowed 4 Divorced White Year or Datas: Completed 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Pages 1 and 2 should be filed within nent of Health and Mentel Hygiene. Int: If Item 27 is marked other than Irry or other traumatic event, the Ma College (1-4or 5+) Elamantary/Secondary (0-12) Clothing 12 Garment Worker 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Eugene Attix Elva Cook 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) Carol Elaine Anderson 217 Magnolia Avenue, Mt Vernon, New York 10552 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20c. Location - City or Town, State Millington, Maryland 20a. Mathod ol Disposition 1 Burial 2 □ Cramation 3 □ Ramoval from Stata permit. Page Depertment of Important: If any Injury or price. Asbury Cemetery - December 30, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral 22. Nama and Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. William L. Kins, M-00937 370 Cypress Street, Millington, Maryland 21651

23a. Pert1. Enter the diseasa, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiretory arrast,
Approximate Interval Batwaar Shock, or heart failure. List only one cause on each line. Intarval Batwaan Onsat and Death **Physician** /Medical Immediata Causa (Final ACUTE MYOCARDIAL INFARETTON disaasa or condition rasulting in death) Examiner Examiner The law requires that the death certificate be executed ettending physician end for use es the bunel-trensit Sequantially list conditions, if any, laading to immediate cause. Enter Undarlying Causa (Dissess or injury that initiated avants resulting in deeth) Last Due to (or as e consequance of) Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ You 3 ☐ Probably 4 ☐ Unknown BILATENAL AMPUTATIONS à 24b. Were autopsy lindings aveilebla prior to complation of causa ol death? 24a. Was an autopsy Completed RHELIMATOID ARTHRITIS peen s certificate has t director, page 2 s MYELDPROLIFERATIVE DISEASE HISTORY OF PULMONARY EMBOLLS M
25. Was casa referred to medical
axaminar? 1 ☐ Yas 2 No al or Attending Physician: The softer death.

I Director: After this certificated in by the funeral director, pa Be 26. Plece of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1□ Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 5 Pending investigation Natural 1 Yes 2 No 2 Accidant 3 Suicida 6 Could not be detarmined 28e. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 4 Homleide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Cartifiar Medical (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licensa number 200

State Registrar 31. Data filed (Month, Pay, Year)
JAN 0 5 2001

Helen Noble, M.D.

30. Nema and address of parson who complated causa of daath (Itam 23a) (Type, Print)

32. Regis far's Signetura

122 Speer Rd. Chestertown, MD.

300 POSE A BUILDI

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1/12/2001 FCHD.KS Certificate of Death Amended item#6 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) Nettie Kathryn Smith 3. Time of Death Month December 20, 2000 5:00 pm 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Deys Months 220-42-6015 Sept 13, 1942 Virginia Usuel Residence of Decedent 10d. tnslde City Limits 10b. County 10c. City, Town or Location Maryland Frederick 1 Yes 2 No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 East 8th Street 21701 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Yeer or Detes: 14. Race - American Indien, 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus Bleck, White, etc. 1 Never Merried 25 Merried 1□Yes 20No Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker self 18. Mother's Neme (First, Middla, Maiden Surname) 17. Fethar's Name (First, Middle, Last) Aubrey Clinton Martin Norma Elaine Whetzel 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. tnformant's Name/Ralationship (Type, Print) Charles Smith / husband 2 East 8th Street, Frederick, MD 21701 20e. Mathoe of Disposition 20b. Plece of Disposition (Name of cametary, cremetory or other plece) 20c. Location - City or Town, Stete 1 Buriel 2 Cremation 3 Removel from Stete 4 □ Donation 5 □ Other (Specify) ResthavenMemorialGardens 12/26/00 Frederick, Maryland 22. Name end Address of Fecility 21. Signeture of Funeral Service Liminson Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 23a. Particular the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, 21702 Approximete Intervel Between Onset end Deeth Immediete Ceuse (Finel diseasa or condition rasulting In death) do Dua to (or es a consequance of) NEU TRUPENIA W84-Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Lest Due to (or as a consequence of): CHEMOTHER APY WEER Due to (or es e consequence of): VARIAN (ANCER 23h. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 | Yes 2 | No 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Wes an eutopsy performed? 10 Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 Nnpatient 2 ER/Outpetient 3 DOA Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 27. Manner of Death 1 Natural 28d. Describe how injury occurred tnjury at Work? 5 Pending invastigation

Examiner the attending physician and hed for use as the buriel-transit The law requires that the death certificata be executed P.O. be deteched been signed by page 2 should Division of Vital filled in by To the Hospital o within 24 hours af To the Funerel Di completely filled in

Physician

/Medical

Examiner

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Director

Funeral

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12 should be fill h and Mental H I is marked off

permit. Pages 1 and 2 st Department of Health and Important: if flem 27 is m

Physician

/Medical

Physician/Medical Examiner

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Be Completed

Certification: To

edical

8

Baltimore,

72 hours after

3 ☐ Suicide 6 Could not be detarmined 4 Homicide

1 Yes 2 | No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

1 Creatifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daeth occurred at the time, data and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one)

29b. Signeture end title of certifier

2 Accident

29c. License number D1058 29d. Dete signed (Month, Dey, Year)

2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AFFA, A GEORGE VICE- PRES 450

FREDERICK 21701

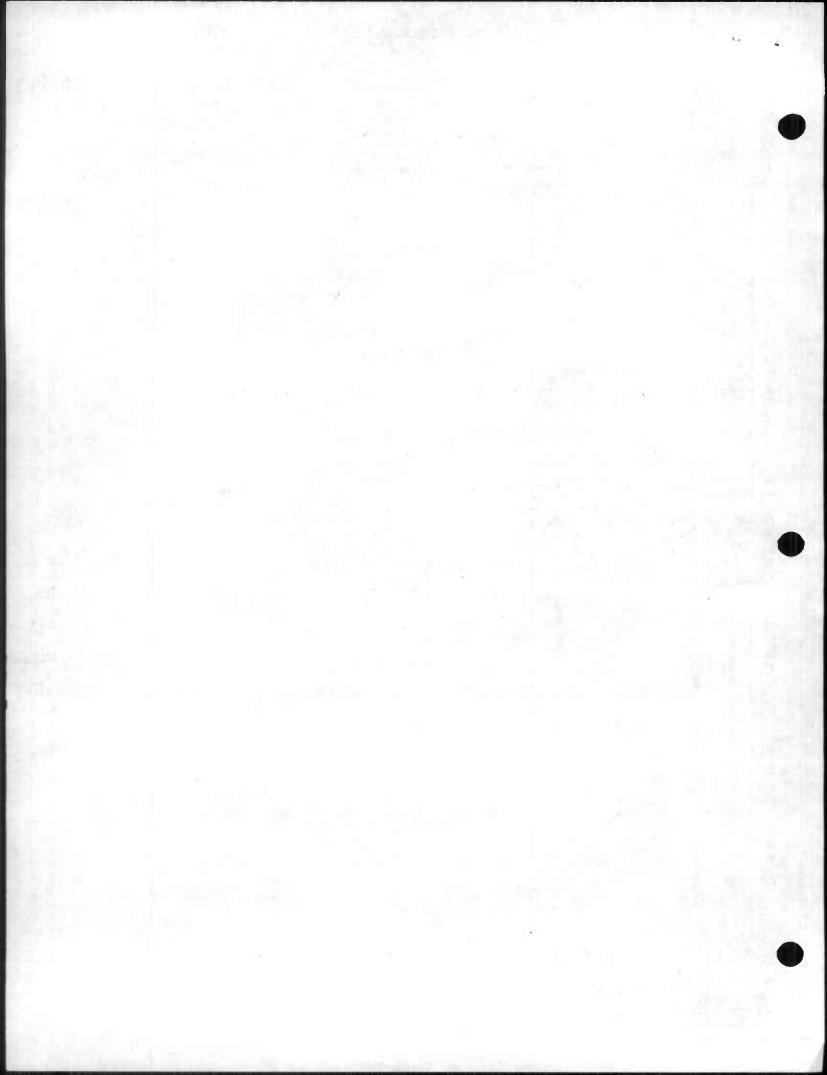
State Registrar

31. Dete filed (Month, Day, Year) DEC 2 6 2000

· SHITH

32. Régistrer's Signature

28a. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

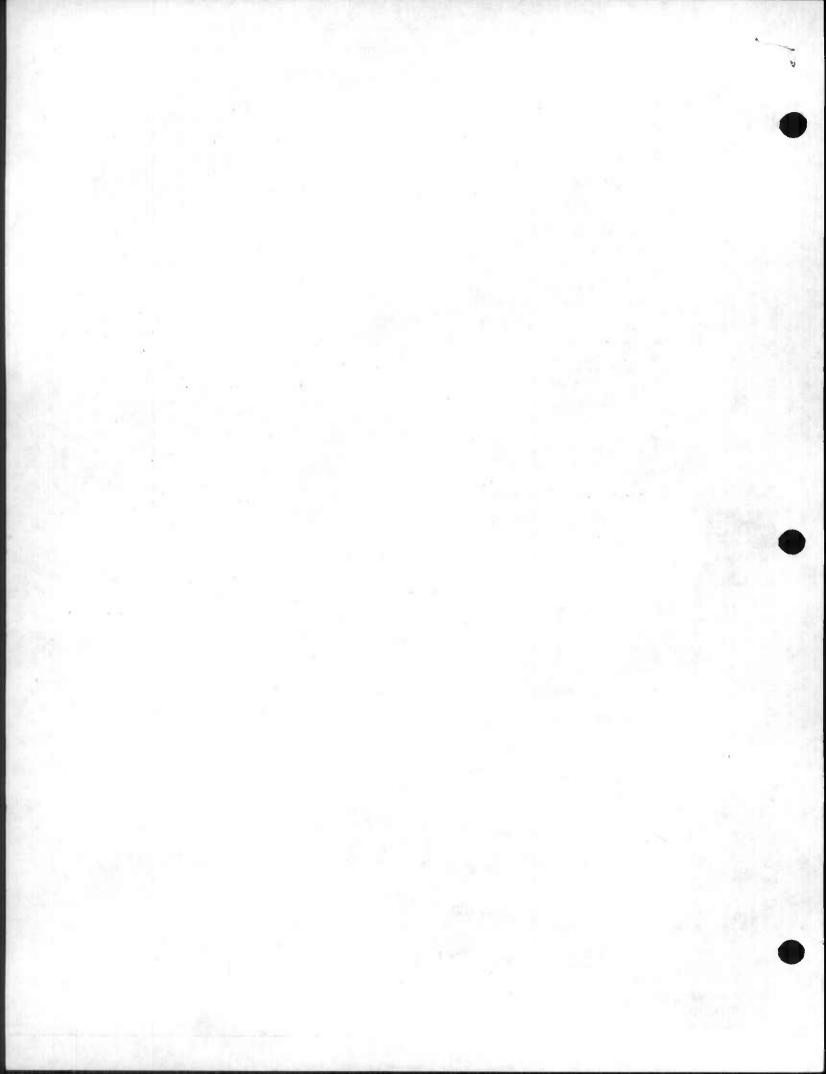


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended item#23 &30per MD FCHD,KS 01/16/01 Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middla, Last) 2. Data of Death **Physician** CAROLYN SIMMS DECEMBER 30, 2000 6:30 A.M. /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, giva street end number) 4c. County of Deeth Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Aga (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Deys Min 1 M 2 F Yes 217-70-3040 49 11,1951 Director JUNE MD. Usual Residence of Decedent with the Meryland 10a. Stete 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahow the Hedgel Examiner must be nothled at FREDERICK 1 Yas 2 □ No MD. FREDERICK Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 424 PENOAK DRIVE 21701 U.S.A. Funeral death 13. Was Decedant of Hispanic Origin? (Specify Yes or No-It Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 12. Was Decedent Evar in U,S. Armed Forces? 11. Mental Status after 1X Never Merried 2 Merried 1 ☐ Yes 2 ☐ No If Yes, Give 0 Baltimore, Maryland 21215-0036 Specify: BLACK 1 Yes 2 XNo Specify: à 72 hours 3 Widowed 4 Divorced Yeer or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade complated) 16b. Kind of Business/Industry SCOTT KEY nd Mental Hygiene. marked other than Elementery/Secondery (0-12) College (1-4or 5+) CAFTERIA HELPER CENTER 10 TH 18. Mothar's Neme (First, Middle, Maiden Surnama) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event page. 17. Fether's Neme (First, Middle, Last) Be WALTER T. SIMMS HILDA R. PAGE 19b. Mailing Addrass (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Coda) 19a. Informent's Neme/Ralationship (Type, Print) CLARA OWENS (SISTER) 19646 WOOTON AVE. POOLESVILLE MD. 20837 20b. Place of Disposition (Neme of cematary, crametory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Date 1 XBuriel 2 Cremation 3 Removel from Stete RESTHAVEN MEM. GARDEN 1-3-01 FRED. MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service License 22. Name end Address of Fecility ollin GARY L. ROLLINS FUNERAL HOME Part 1. Enter the dissesa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or head ailure. List only one cause on each line. 21701 Approximeta Interval Between Onsat and Death **Physician** Immediate Ceusa (Final disaasa or condition resulting in deeth) /Medical Respirator Examiner Examiner aspiration pneumonia physician and the bunal-trensit The lew requires that the death certificate be assecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or es a consequança ot): Division of Vital Records, P.O. Box 68760, seizures Physician/Medical Dua to (or es a consequence of): thet initieted events resulting in death) Lest 88 syndrone Downs USB signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 210 No 3 Probably 4 Unknown 1 Yes dementa Azheiners by 24b. Were eutopsy tindings available prior to pluods 24e. Wes en eutopsy performed? Completed been s anemia complation of cause of death? page 2 After this certificate has NO an Physician: 25. Wes casa rater ad to medical exeminer? Be 26. Plece of Daath (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1/Nnpatient 2 2 ER/Outpatient 3 □ DOA 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury et Work? Hospital or Attending 1 Salatural 2 Accidant 5 Panding investigation Injury death. 1 Yes 2 No ours after death eral Director: A filled in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, term, street, tectory, office building, atc. (Specify) 4 Homicida within 24 hours a
To the Funeral I
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner stated. 29a. Certifier edical (Check only one) 29c. License number 29d. Data signad (Month, Dey, Year) 29b. Signatura and titla of certifier 053129 90 NO 30. Nema and address of person who completed cause of deeth (Item 23a) (Type, Print) 21703 610 MO 27103 SOLAREX CT FREDERICK HEITZIG MD 31. Date filed (Month, Dey, Year) JAN 0 5 32. Registrar's Signetura State 2001 Registrar

ORIGINAL

DHMH 16 Rev 6/95



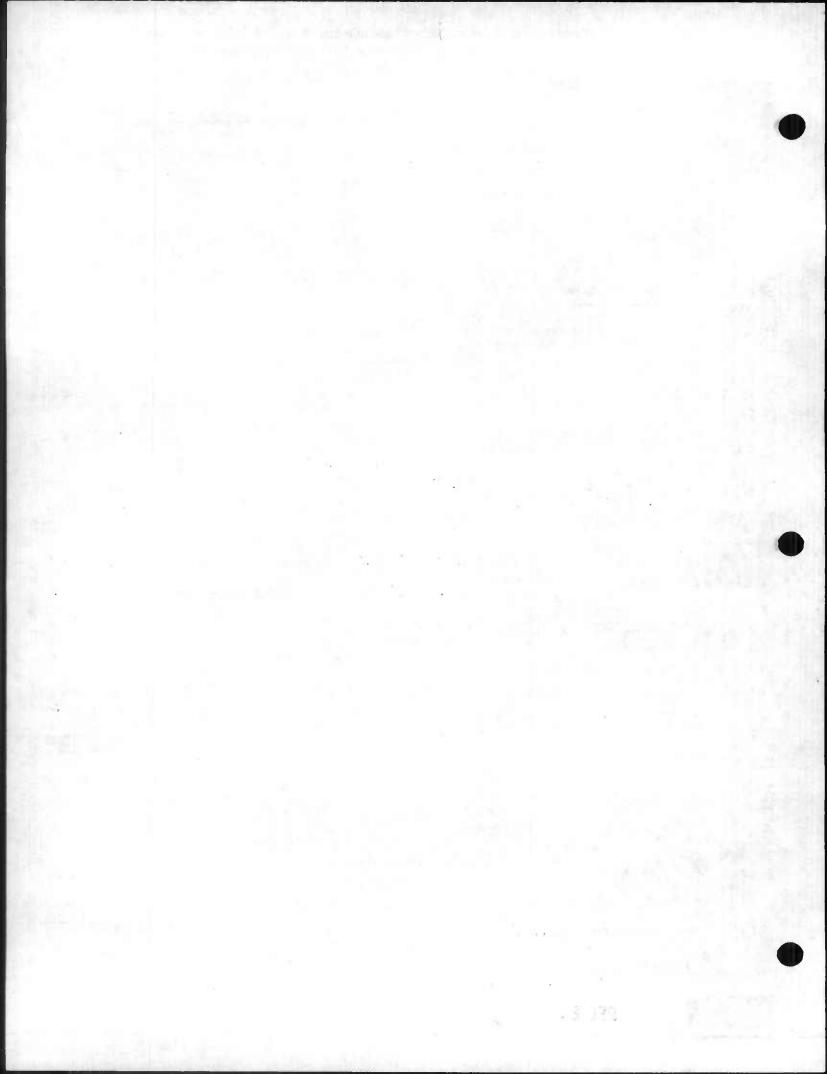
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Month Year **Physician** Elwood Lee Tucker 16, 1905 Dec. 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hospital Talbot The Memorial Easton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) January 16, 1933 9. Birthplace (State or Foreign Rock Hall, MD 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Min. Days 1MM 2□ F Months Hours 67 214-28-8410 Director Usuel Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8238 Broadneck Road 21620 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. 72 hours after 1 Never Married 2 Married 1 Yes 2 No Specify: specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Elementary/Secondery (0-12) 12 College (1-4or 5+) Fire Fighter Airline 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be Thomas Adkins Tucker Margaret Burgess and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 r ment of Health ar Ħ Department of Health Important: If Item 27 Barbara Turner Tucker 8238 Broadneck Road, Chestertown, MD 21620 Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Buriel 2 □ Cremation 3 □ Removal from Stete ò 4 ☐ Donation 5 ☐ Other (Specify) Wesley Chapel cemetery 12/19/2000 Rock Hall, MD 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home, P.A. 21. Signature of Fuperal Service Licen 130 Speer Road, Chestertown, Maryland 21620 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one was on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Mins Cardiac Arrest Secondary to Examiner Due to (or as a consequence of): Examiner Mins Acute Myocardial Infarction the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Years Box 68760 Coronary Artery Disease Physician/Medical Due to (or as a consequence of): Years ASHD Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Honknown The law requires that Records, þ 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Wes an autopsy performed? page 2 should Completed After this certificate has 1 Yes 2 PNo Division of Vital Physician: 25. Was case referred to medicel examiner? director 80 26. Place of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 1 ☑Natural 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred epital or Attending P nours after deeth. neral Director: After t filled in by the funera 5 Pending investigation 1 TYes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C completely filled Hospital edical (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of contine 29c. License number D02772 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edmund J. Fitzgerald, 505 Dutchman's Lane, Easton, MD 21601 31. Date filed (Month 32. Registrar's Signature State Registrar

DHMH 16 Ray 6/95

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Time of Death Month Dec. Rebecca Iola Turner 11:57 p.m. 2000 4e. Fecility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Kent & Queen Anne's Hospital Chestertown Kent 5. Sociel Sacurity Number 7. Age (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) 1 M 2 F 219-46-4155 54 Yrs May 1, 1946 MD Usuei Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. fnsida City Limits Kent Rock Hall 1 TYAS 2KINO 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 5525 Crosby Road 21661 U.S.A. 12. Wes Decedent Evar in U,S. Armed Forces? Was Dacedant of Hispanic Origin? (Specify Yas or Noff Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indien, Bieck, Whita, atc. 1 ☐ Yas 2 ☒ No If Yes, Give Year or Datas: 1 Navar Married 2 No Merried 1 Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced Black 16e. Decedent's Usuei Occupetion (Give kind of work done during most of working iife. DO NOT use retired) 15. Decedent's Education (Specify only highast greda completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 12th College (1-4or 5+) Marina Housekeeper 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Russell Scott Clara Sisco 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Ernest Turner Husband 5525 Crosby Rd., Rock Hall, MD 21661 20b. Pleca of Disposition (Neme of cametary, crematory or other plece) 20e. Method of Disposition 20c. Location - Cify or Town, Steta 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State Aaron Chapel Cemetery 12/23/00 4 Donetion 5 Other (Specify) Rock Hall, MD 21. Signeture of Funerel Sarvice Licansee 22. Nama and Addrass of Facility James A. Perkins Funeral Service P.O.Box 148, 21106 Rock Hall Ave., Rock Hall, MD Approximate 661 23e. Pert1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errast, shock, or heart feilure. List only one cause on each line. Interval Between Onsat and Death Immediete Ceuse (Final disaasa or condition resulting in deeth) Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es e consequence of)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

MD

Director

Funeral

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Completed

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Funeral

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tem 27 is marked other than "naturel", or items 23s or 28s-f show other traumstic event, the Medical Examiner mant be notified at

permit. Pagas 1 and 2 should be filed within 72 hours aftar death \ Department of Haath and Mental Hygiane. Important: If them 27 is marked other than "naturef; or frems 23s eny fulury or other traumatic event, the Medical Emerical Committee main.

Baltimore, Maryland 21215-0020

with the Maryland

Physician/Medical p Completed Be

29b. Signature end title of certifier

31. Dete filed (Month, Day, Year)

DEC

30. Name end address of person who completed gause of deeth (Item 23e) (Type, Print)

32. Registrer's Signeture

physician and s the bunal-transit Division of Vital Records, P.O. Box 68760, attanding signed by the atta has certificate

To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, Certification: edical

Part II. Other significen	t conditions co	ntributing to death but not re	esuiting in the underlyin	g cause	e given In Pert I.	23b, D	id tobacco uee co	ntribute to the caues of death?
1 Zay	e Be	d sores	D Buch	ch		1	□ Yee 211 No	3 Probably 4 Unknown
@ Pare	pleg	a					as an autopsy rformed?	24b. Were eutopsy findings eveilable prior to completion of cause of death?
						- 10	Yas 2010	1 ☐ Yes 2 ☐ No
25. Wes case referred t	o medical				28. Plece of De			1 Yes 2 No
25. Wes case referred to examiner?	-	Hospitel: 1 Prinpatient 2	☐ ER/Outpatient 3☐	DOA	28. Piece of De	eth (Check on		
examiner? 1 Yes 2 No 27. Menner of Deeth 1 Neturel 5 2 Accident	-	Hospitel: 1 Inpatient 2 28a. Dete of Injury (Month, Dey Year)	28b. Time of	28c. I	Other	eth (Check on	y one)	er (Specify)

29c. Licansa number

D21313

29d. Dete signed (Month, Dey, Year)

Washington Ave., Chestertown, no 21620

State Registrar Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend item 2 per md G792 2/15/01 yf State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended #19, 12/18/00, cwc, Kent Co. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month December Day **Physician** David Howard 2000 0720 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Kent & Queen Anne's Hospital, Inc. Chestertown Kent If Under 24 Hrs. 8. Date of Birth Hours Min. April 25, 1926 If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Deys 74 Cumberland, MD 212-24-2027 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 25a-f show 1 ☐ Yes 2 No Director Chestertown Kent Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 **IISA** Norms 23a 10705 Tilden Lane 21620 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☑ Merried 8 Baltimore, Maryland 21215-0020 White 1 ☐ Yes ŽXNo Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene.

smithed other than "na Elementary/Secondery (0-12) College (1-4or 5+) Owner/Operator Broadcasting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Olive Cox Howard Taylor and al 19e_Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Pages 1 and 2 ament of Health an Joanne Jody Taylor Department of Health a Important: If New 27 is any injury or other trau 2009. 10705 Tilden Lane, Chestertown, MD 21620 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 12/11/2000 Kennedyville, MD Shrewsbury Cemetery 4 Donation 5 Other (Specify) 21. Signeture of Funerel Service Licenses Fellows, Helienbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620 rux 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final ACUTE LEUKEMIA 2 Weeks disease or condition resulting in death) Examiner Physician/Medical Examine The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Box 68760, Due to (or as a consequence of) P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown MYELODYSPLASIA of Vital Records, þ 24b. Were eutopsy tindings available prior to completion of ceuse of deeth? Be Completed 24a. Was an autopsy PNEUMONIA 1 Yes 2 No 1 ☐ Yes 2 No or Attending Physician: 25. Was cese referred to medicel examiner? 26. Plece of Deeth (Check only one) Hospitel: 1 panpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28c. tnjury et Work? 28d. Describe how injury occurred 28b. Time of Division 1 Naturel 2 Accident 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No investigation 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide TESCertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) A When mo 50 15 + 30. Neme end address of person who completed ceuse of death (Item 23a) (Type, Print) Helen A. Noble, 122 Speer Road, Chestertown, Maryland 21620 1 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

DEC 12 2000

Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended item #'s/4/8/WCHD/MAP 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 1125 George Stanley December 30 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar. 30 1922 9. Birthplace (Stata or Foraign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min 1 M 2 F 2₂15-26-2395 78 Yrs. Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Wicomico Quantico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 223106 Royal Oak Road 21856 U.S.A 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Laborer None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumame) Millard Wilson SR. Marylayers Fields 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Agnes Wilson (Wife) 223106 Royal Oak Rd.Quantico Md.21856 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 KBuriel 2 ☐ Cremation 3 ☐ Removal from State Odd Fellows Cemetery 4 ☐ Donetion 5 ☐ Othar (Specify) Wetipquin, Md. 22. Name and Address of Fecility Stewart Funeral Home 821 West Rd.Salisbury,Md.21801 Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that ceused the dishock, or haart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) and in Dua to (or as a consequence of): concer Sequentially list conditions, if any, leading to immediate ceusa. Entar Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings 24e. Wes an autopsy performed? available prior to completion of ceuse of death? 2 X No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case raferred to medical 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA 27. Mannar of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Tima of 5 Pending investigation Injury 1 Natural 1 Yes 2 No 2 Accidant 6 Could not be determined 3 Suicide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide

Examiner Examine Physician/Medicai 950 Completed by page of Vital Physician: Be this After slon or Attending death. after death within 24 hours a To the Funeral D completaly filled Hospital

Physician

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Department of Heelth and Important: If New 27 is man any Injury or other traumat

Physician

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Completed

edicai Certification: 29e Certifier 29b. Signeture and title of certifie 30. Name and addrass of person who completed ceuse of death (Item 23a) (Type, Print)

William

Registrar

KODINS Mis. 1104 32. Registrar's Signature 31. Date filed (Month, Day, Year) JAN 0 5 2001

112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or invastigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

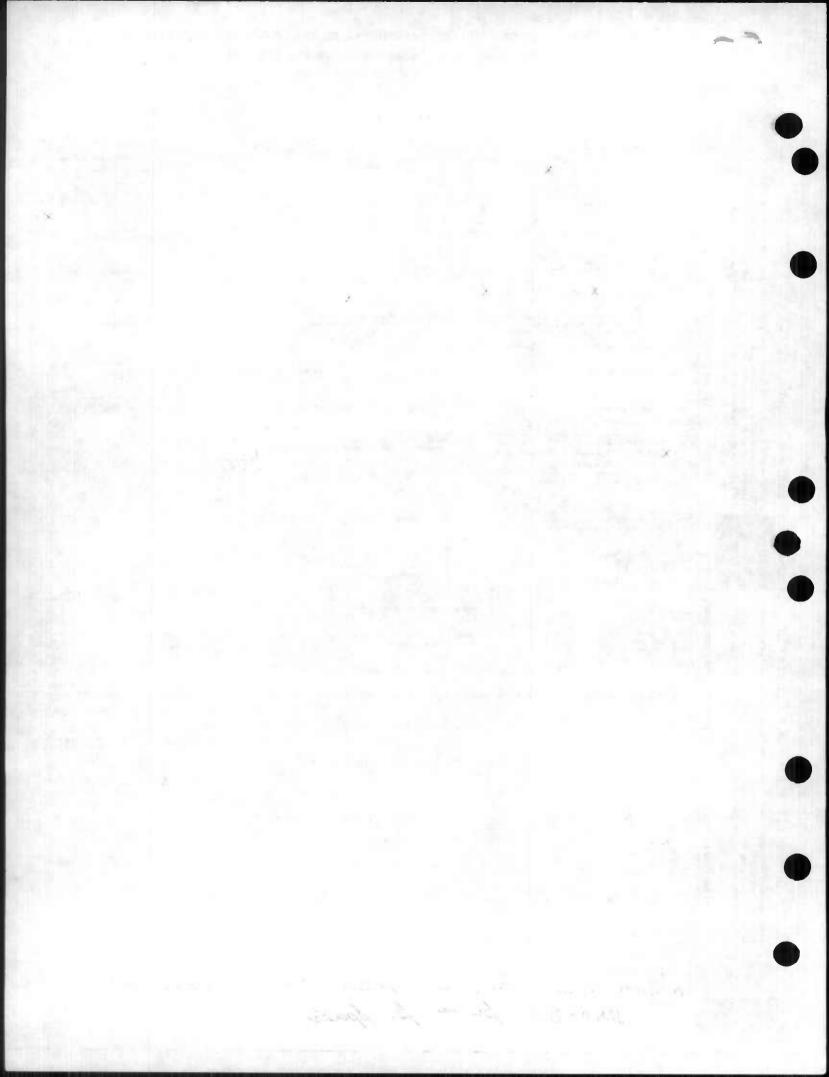
29c. License number

29d. Date signed (Month, Dey, Year)

SALIS BURY

DHMH 16 Rev 6/95

To the



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death **Physician** Charles Whaland White 21 1730 December 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner The Kent and Queen Anne's Hospital, Inc. Chestertown Kent 8. Data of Birth (Month, Day, Year) 9. Birthpiace (Scientry)
June 27, 1931 Chestertown, MD 7. Aga (In yrs. last birthday) If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 6. Sex. 1 → M 2 □ F **Funeral** Months Days Hours 214-28-1628 Director Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 21 No 288-71 Directo Maryland Queen Anne's Chestertown the Medical Examiner must be notifi-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Herns 23a or USA 21620 104 Longfellow Drive Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ∑ No If Yas, Giva Year or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14 Bace - American Indian Black, Whita, atc. 1 Never Married 2 Married Maryland 21215-0020 8 1 ☐ Yas Ž\ONO Specify. White à 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 16h Kind of Business/Industry Do filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Pressman/Photographer Printing 8 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) h and Mental is marked of Sara Elizabeth Elliott William R. White 19b. Mailing Address (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s mant of Health an 104 Longfellow Drive, Chestertown, MD 21620 Alice Diane White Department of Health Important: If Item 27 Baltimore, 20b. Placa of Disposition (Nama of cemetery, cremetory or other place) 20c. Location - City or Town, Slate 20a. Mathod of Disposition 1 XBurial 2 Cremation 3 Removal from Stata 8 12/27/2000 Chestertown, MD 4 □ Donation 5 □ Othar (Specify) Chester Cemetery 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility any is Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 23a. Part1. Enter the miles of complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata tntarval Batween Onset and Death Physician Immediata Causa (Final diseasa or condition rasulting in death) /Medical a, angendore entences preumoni Examiner Dua to (or as a consequence of) Certification: To Be Completed by Physician/Medical Examiner Delinium The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) renal Box 68760. Stage that initiated events rasulting in death) Last Dua to (or as a consequence of): Mypokalemi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown mellitus, congestive heart of Vital Records, 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Evarantis, AV graft hemotoma To the Hospital or Attending Physician: The law within 24 hours after death.

To the Fueral Director: After this cartificate has b completely filled in by the funeral director, page 2 s 1 Yas 20 No 1 Yes 25. Was casa refarred to medical 26. Placa of Death (Check only ona) Hospitel: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yes 20 No 27. Manner of De 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred Division Naturel 5 Pending investigation 1 Yas 2 No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At homa, farm, straal, factory, office building, atc. (Specify) 4 T Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, data end place, and due to the ceuse(s) end menner as stated.

| Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Cartifier (Check only one) 29b. Signatura and titla of certified 29c. Licansa number 29d. Data signed (Month, Day, Year) 10051735 MD 30. Nema and address of person who completed causa of daalh (Item 23a) (Type, Print) 6602 Church Hill Road, Suite 200, Chestertown, MD 21620 Frederick Delboy, 31. Data filed (Month, Day, Year) State

Registrar

DEC 2 6 2000

32. Registrar's Signatura

B. Agrant

MOST SOF

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 3 5 2 3

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) DECEMBER 20, 2000 **Physician** 11:35 PM ELEANOR E. BUTZ /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Future Care Chesapeake Arnold Anne Arundel Birthpiace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1□M 20 F Months Days Hours 147-10-4256 92 Yrs. Oct 15, 1908 New Jersey Director Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health end Mental Hygiene.
Important: If item 27 is merked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Example to north 54 and 2008. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Arno1d 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 College Parkway 21012 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 Ñ No tf Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. Black, White, etc. 1 □ Never Merried 2 □ Married 1 Yes 2 No Specify: Specify: White à 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) Assistant librarian education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be Joseph J. Phillips Elizabeth McGarrigle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stafe, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Harold Butz/son 551 Norton Lane Arnold, MD altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee Ronald S. Wade, Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street man 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Baltimore, MD Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final emen disease or condition resulting in death) Examiner Examiner astrountes tina propol physician end s the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760, remia Physician/Medical Due to (or as a consequence of): 98 esn ō signed by the e 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 29 24b. Were autopsy findings evaileble prior to completion of cause of death? 24e. Was an autopsy Completed pege 2 s 1 Yes 2 X No 1 ☐ Yes 2 ☐ No certificate i or Attending Physician: after death. Director: After this certifica funeral director 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Saturai 5 Panding 1 Yes 2 No 2 Accident investigation 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide 24 hours a Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the I within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 40519 12-29-00

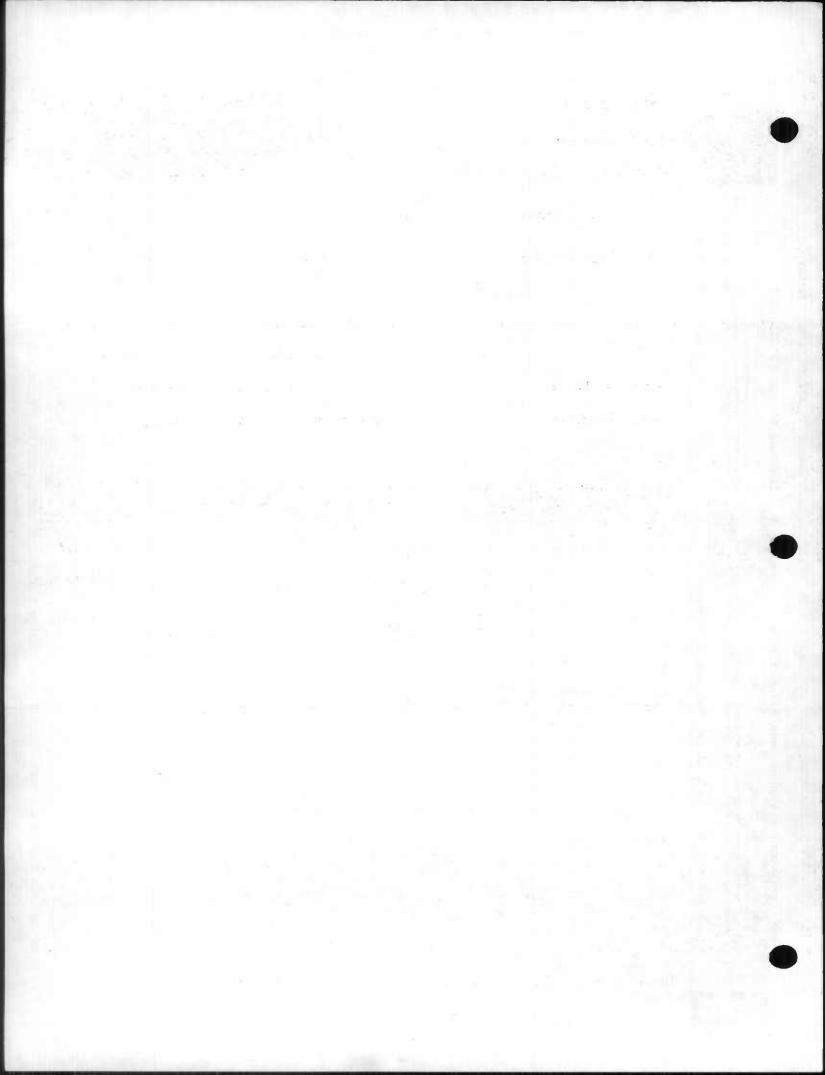
7845 OAKWOOD Prop Bldg, Suite 200, Colon Burne, 2106,

State Registrar 30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print)

32. Registrar's Signature

MIRCH M. NUSAIRED 31. Date filed (Month, Day, Year)

Elleanor But



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death Amended Item#23a,24a,25 perPHYG791 1/23/2001 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month VIRGINIA COVINGTON 12 25 2000 8:53am 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 601 Wyanoke Ave. Apt. 502 Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) Months Days 1□M 2X F Yrs. 212-44-0692 3/10/35 Va Usual Residence of Decedent 10b. County 10a. Stete 10c. City, Town or Location 10d. Inside City Limits Y☐ Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 Wyanoke Ave. Apt. 502 21218 USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, 11. Maritat Status Bieck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☐No If Yes, Give Specify: Black 1 Yes 2 No Specify: 3 ☐ Widowed 4 X Divorced Yeer or Dates: 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 4th Grade Farmer Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Acree Myrira Simmons 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Crystal Covington 2401 Westport St., Balto., Md. 21230 20b. Pleca of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 X Burial 2 Cremetion 3 Removet from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Clark United Meth Ch Cem. 12/29/00 Belair, Md. 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility 21202 Baltimore, Md. March F.H. East 1101 E. North Ave., 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Death ATHERIOSCLEROTIC CARDIOVASCULAR DISEASE Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): 1112 10 Sequentietly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or as e consequenca of): Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24e. Wes an autopsy performed? CEI describer dispose 1 Tyes 2 No 25. Was case reterred to medice! examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Desidence 6 □Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menuter of Deeth 28b. Time of 1 Neturel 5 Pending

^rhysici⊾n /Medica Examine physician and the burial-transit the death certificate be exacu for use as 1 signed by the a certificate has b this funerei After death. To the Hospital or Attenditional within 24 hours after death To the Funeral Director: A completely lilled in by the f

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

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Funeral

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Hygiene. "naturel", or flems 23s or 28s-f show off, the Medical Exercise must be notified at

with the Maryland

deeth v

filed within 72 hours after

. Pages 1 and 2 should be filled w timent of Health and Mental Hygien tant: If item 27 is marked other th jury or other traumatic event, the

permit. Pag Department Important: If any injury or once.

Baltimore, Maryland 21215-0036

P.O. Box 68760 Division of Vital Records,

(Check only

31. Dete filed (Month, Pay, Year) 3

29e. Certifier

2 ☐ Accident

3 ☐ Suicide

4 Homicide

29b. Signeture end title of Carling

28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

 Location (Street end Number or Rural Route Number, City or Town, Stete) 1 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es stated.

Belgraremo

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner steted. 29d. Dete signed (Month, Dey, Year) 29c. License number

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

200

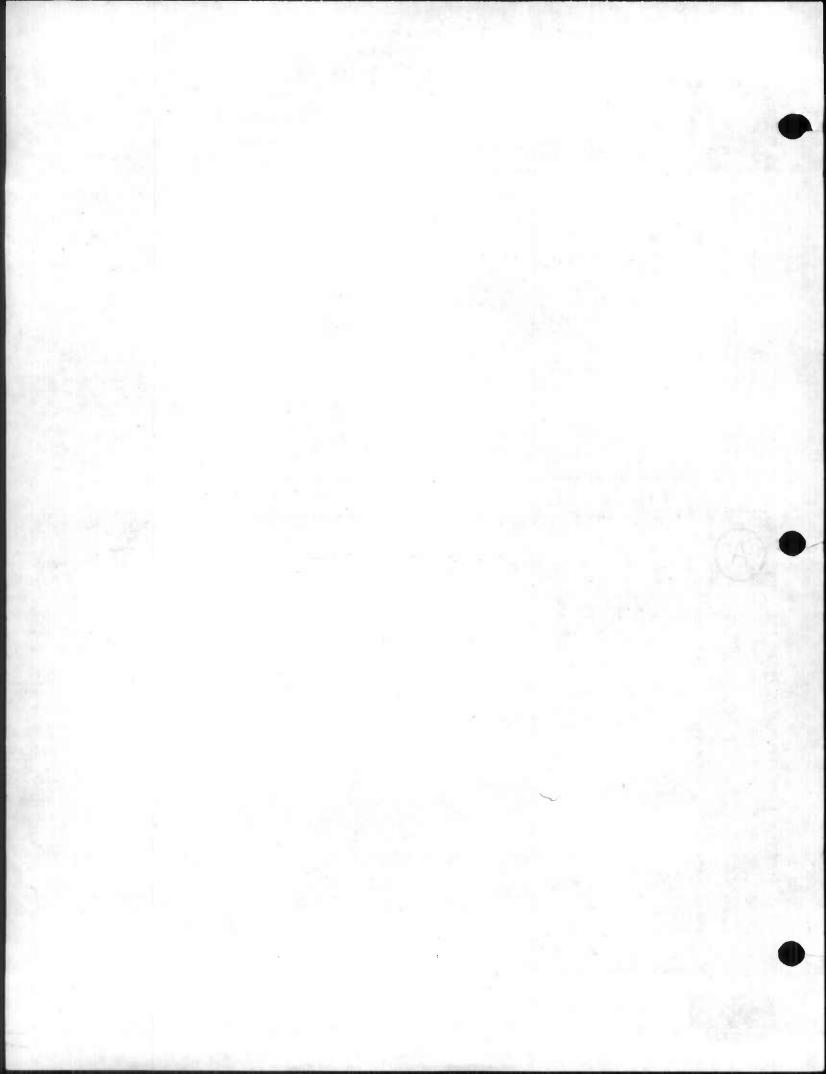
investigation

6 Could not be determined

M D 32. Registfer's Signeture

4.

State Registrar



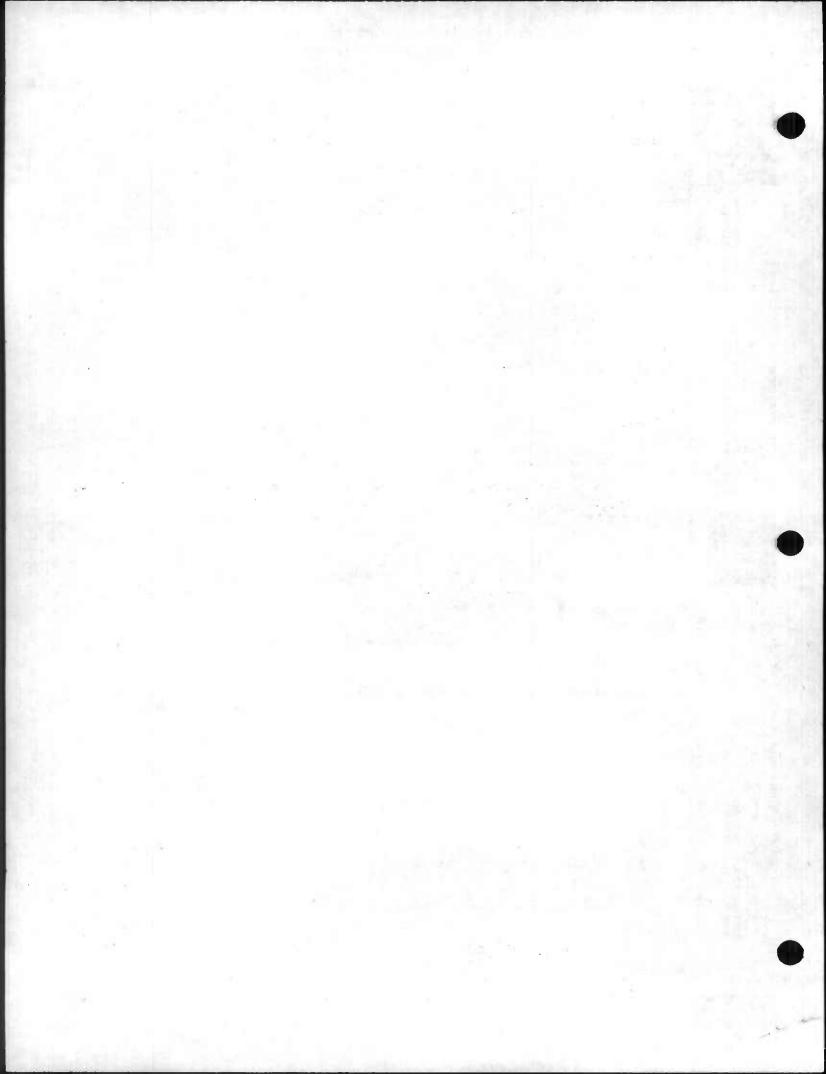
00-7541-510 jhm ROBERT LLO

Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible 3 5 2 5 State of Maryland / Department of Health and Mental Hygiene

M .		State of Marylan		te of Death		Reg. No.			
Physician (Madical	Decedent's Name (First, Middle, Las ROBERT LLOYD	it)		1	2. Date of De Month DECEMI	Day	Year 2000	3. Time of Death 00:07 AM	
/Medical Examiner	4a Facility Name (If not institution, give HARBOR HOSPITAL	a street and number)		4b. City, Town, or BALTIM	Location of Death		of Death	00.07.121	
Funeral Director	5. Social Security NumberUnk 6. So	ex M 2□ F 7. Age (In yrs. 40	AA	r 1 Yaar If Under 24 Hrs	8. Date of Bir	of Birth Day, Year) 5, 1960 9. Birthplace (State or Fo Country) unk			
the Maryland 28a-f show notified at sector	Usual Residence of Decedent 10a. State 10b. County Anne Aru	indel 10c. Cit					0d. Inside City Limits 1 ☐ Yes 2 No		
€ 5 Z O	10e. Street and Number 6664 Shelly Avenu	e	10f. Zi	21061	Vhat Coun	try?			
Para Para Para Para Para Para Para Para	11. Marital Status unk 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Yaar or Dates:	,S. 13. Was Dece if Yes, spe nk 1 Yes		/ Cuban, Mexican, Puarto Rican, etc.)			14. Race - American Indian, Black, White, efc. Specify: white	
within within and. the Men.	15. Decadent's Ed (Specify only highest gra Elementary/Secondary (0-12) UNK	ucation de completad) College (1-4or 5+) nk	16a. Decedent's Usu (Give kind of we life. DO NOT u	al Occupation ork done during most of wo ise retired)	unk unk	16b. Kind of Bu	siness/Inc	lustry unk	
tryland 2 thould be filed ad Mental High marked other matic event, I	17. Fathar's Name (First, Middla, Last)	unk		18. Mother's Na	me (First, Middle	, Maiden Surnam	e) u	nk	
ore, Marylanc	19a. Informant's Name/Relationship (7 O . C . M . E .	Type, Print)	19b. Mailing Addres	Street Bal	ural Route Numb			Code)	
altimore	20a. Method of Disposition 1 Burial 2 Cramation 3 4 Donation 5 Other (Specify	Ramoval from State	Place of Disposition (Na cemetery, crematory or	me of	Date	20c. Location -	City or To	wn, Slate	
Balt permit Depart import any inj ansa	21. Signature of Ameral Service Licen Ronald S.	Wade, Director	nd Address of Facility Anatomy Boar ore, MD 212	Address of Facility natomy Board 655 W. Ba			Saltimore Street		
Physician /Medical	23a. Part1. Enter the disease or company of the shock, or heart failure. List only of the shock			da of dying, such as cardia	c or respiratory a	rrest,	1	Approximate Interval Between Onset and Death	
Examiner	disease or condition resulting in death)	Ruptured my	Tamponade or as a consequence of ocardial in	ifarction con	mplicati	ng ather	oscle	erotic	
68760, ficate be executed physician and as the bunal-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b. cardiovascular disease and cocaine intoxication Due to (or as a consequence of):							
W # D 0	that initiated events resulting in death) Last	Due to (o	or as a consequanca of)						
P.O. net the d d by the detached	Part II. Other significant conditions or	ontributing to death but not res	sulting in the underlying	cause given in Part I.		tobacco use con		o the cause of death? bebly 4 Unknown	
Division of Vital Records, or Attanding Physician: The law requires to after cleath. Director: After this certificate has been signed in by the funeral director, page 2 should be ertification: To Be Completed by						an autopsy ormed?	av	ere autopsy findings ailable prior to mpletion of cause death?	
Vital Relation: The law certificate has rector, page 2	25. Was case referred to medical			26 Place of De	1)X	Yes 2 No	1)	Yes 2□ No	
of Vita hysician: his cartific al director. To Be	examiner? 1 Styles 2 No	Hospital: 1 ☐ Inpatient 2√2	DER/Outpatienf 3 D	Other	Homa 5 ☐ Resi		er (Specif	y)	
g Ph ge Ph neral	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Dey Year)	28b. Time of fnjury	28c. tnjury at Work?	28d. Describe	how Injury occur	red	5 2 11 2 1	
Sion andin ar: Af he fu	2 Accident investigation	12_30_2000	11:15 p ^M	1 ☐ Yes 2 💢 No	Subject	Subject ingested drugs			
Division of Vital Remains to the Hospital or Attending Physician: The Leminia 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	4 Homicide	3 Suicide 6 Could not be 28e. Place of thiury - At home, farm, street, factory, o			fice 28f. Location (Street and Number or Aural Route No. City or Town, State) 6664 Shelly Anne Arundel County, Ma			, Maryland	
the Hosp hin 24 hot the Fune npletely fi	(Check only one) 2 Medical Exam	ysician: To the best of my kno ilner: On the besis of examina and mannar stated.	ation and/or investigation	n, in my opinion, death occ	e, and due to the curred at the time,	date and place,	and due to	the cause(s)	
or or on	29b. Signature and title of cedifier	Milt		OCME		29d. Date signe DECEMBE			
	30. Name and address of person who of the state of the st	completed cause of death (fter	111 Penn S	treet, Balti	imore, Ma	aryland	2120 1		
State Registrar	JAN 23 20	01 Dependent	B A	ands					

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 43526 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year 35 Am mi 0 2000 4e. Facility Name (If not institution, give street and number)

4b. City, Town, or Location of Deeth

Catonsville

4c. County of Deeth

Baltimore

as

Physician /Medical Examiner **Funeral** Director Peges 1 end 2 should be filed within 72 hours after death with the Merylend nent of Heelth and Mental Hyglene.
int: If Itam 27 is marked other than "natural", or Items 23a or 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0020 other Depertment of Important: If Important: If any injury or once. ò

Mariner Health of Catonsville

Physician /Medical Examiner

certificate be executed

Division of Vital Records,

Attanding Physician:

death.

Hospital or Attandi 24 hours efter death. Funeral Director: A

within 2.

Examiner physician end s the burief-trans Physician/Medical 10 980 for deteched by 8 Completed page 2 funeral director, Be O_L Certification:

Medical

warieling

31. Dete filed (Month, Dey, Year)

JAN 23 2001

30. Name end eddress of person who completed cause of deeth (Item 23ff) (Type, Print)

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32. Registrer's Signature

signed by

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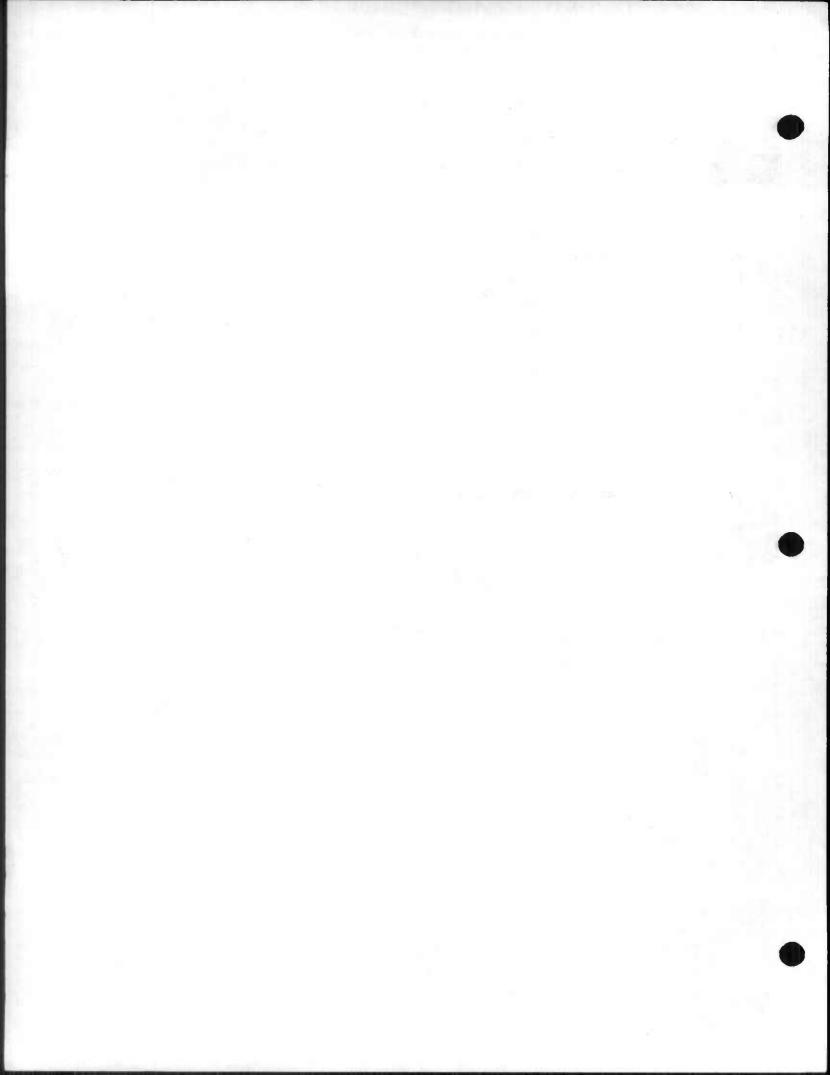
If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) unk. Deys Months Hours 1 M 2 F 213-30-3888 66 Yrs June 16, 1934 Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Catonsville MD Baltimore 1 Yes 2 No Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? USA 98 Smithwood Avenue 21228 Funeral Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 No þ Specify: Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk Eiementery/Secondary (0-12) College (1-4or 5+) 8 17. Father's Neme (First, Middle, Last) unk 18. Mother's Name (First, Middle, Meiden Sumeme) unk Be P 19e. Informent's Neme/Relationship (Type, Print) unk 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk 20e. Method of Disposition 20b. Pleca of Disposition (Neme of Dete 20c. Location - City or Town, Stete cemetery, cremetory or other place) 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 □ Donetion 5 € Other (Specify) in state 22. Neme end Address of Fecility State Anatomy Board 655 W. Baltimore Street Baltimore, Md 21201 21. Signeture of Funerel Service Licenses Ronald S. Wade, Director per DVR 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear feilure. List only one cause on each line. Approximate Intervel Between Onset end Death Immediate Ceuse (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings eveilable prior to completion of cause of death? 24e. Wes en autopsy performed? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 dursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Neturai 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred et the time, dete end plece, end due to the ceuse(s) end manner stated. 29a. Certifier (Check only one) 29b. Signeture and title of cartifier 29c. License number 29d. Dete slame (Month, Dey, Year)

Registrar

State

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien Amended Item#8,23a perPHYG791 /25/2001 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death **Physician** Month Boydner 0015 onla 2 23 2000 /Medical 4c. County of Death 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth Examiner Hospital CONTIV Balt nove Worthwest Randallstown | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Dete of Birth 11/14/22 | 9. Birthplace (State or Foreign Country) | W. C. 5. Social Security Number 8. Sex 7. Age (In yrs. last birthdey) **Funeral** Sex 1DM 2□F 242-26-5013 7 7 Yrs. Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or flams 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Balto Randalls tow. Md Director 10e. Street and Number 10g. Citizen of What Country? 21133 Funeral Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian Black, White, etc. 11. Meritel Stetus 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0036 1 Yes 2 No Specify py Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NQT use retired) 16b. Kind of Business/Industry Warrer Elementery/Secondary (0-12) 5 Un growere College (1-4or 5+) Kooter Be 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) permit. Pages 1 and 2 should be file

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Important: if Nem 27 is marked oth

any linjury or other treumatic event Boyd Innie 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2//33 19e. Informent's Neme/Relationship (Type, Print) 1), llains Kan dulistown, ma Jannie 20a. Method of Disposition

1 Buriel 2 Cremetion 3 Removet from Stete 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete Date cemetery, crematory or other place) 4 ☐ Donetion 5 ☐ Other (Specify) Janey 21. Signeture of Funeral Service Licenses Name end Address of Facility 2/2/5 F. H. Ballo Mel Wapash 300 Approximate Intervel Between Onset end Deeth Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock or heart feilure. List only one cause on each line. ACUTE MYOCARDIAL, INFARCTION **Physician** immediate Cause (Final disease or condition resulting in death) /Medical 2 HOURS Examiner ORONARY ARTERY DISEASE YEARS Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last nding physician and use as the bunal-tran Due to (or es e consequence of): Box 68760, Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been signed by should be detac Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? Completed page 2 2 1 No 1 Yes 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after deeth.

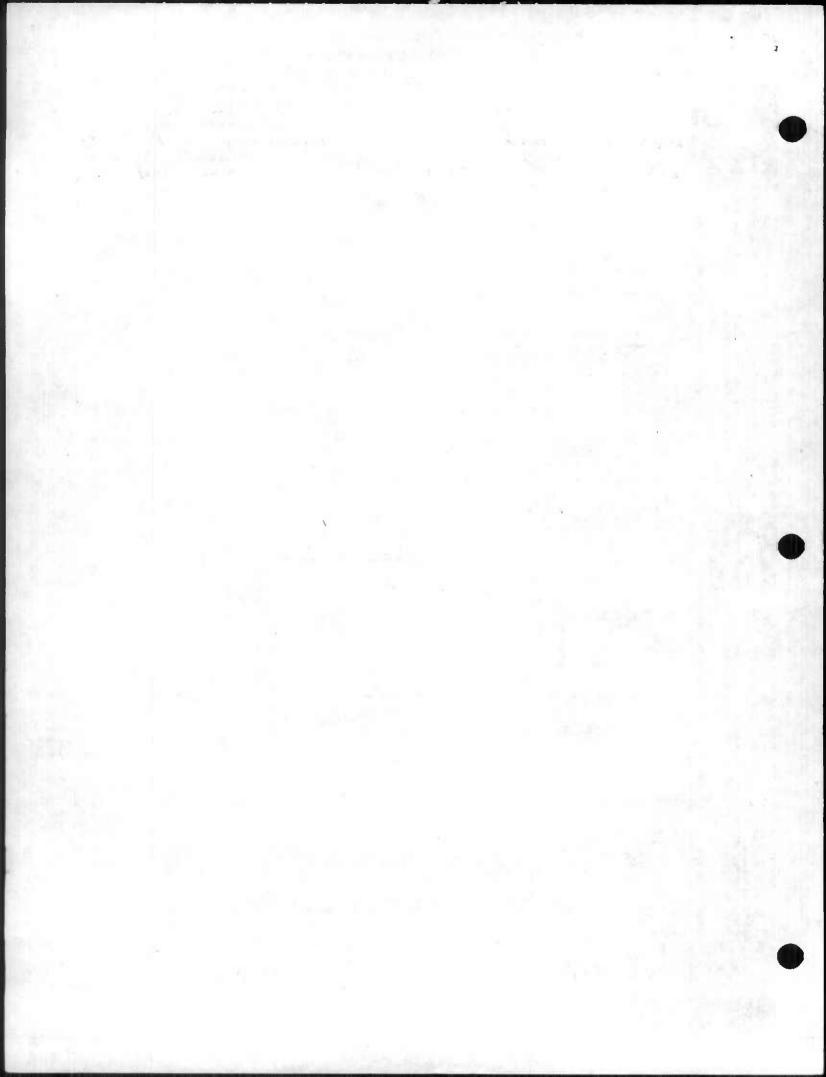
To the Funerel Director: After this certifica 25. Wes case referred to medical Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 10 28c. Injury at Work? 27. Menyler of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end menner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signeture 29c. License number 29d. Date signed (Month, Day, Year) who completed ceuse of death (Item 23a) (Type, Print) Northwest Hop Center R Spenus 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State JAN 2 5 2001 >

DHMH 16 Rev 6/95

Registrar

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible 3 5 2 8 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth December 29,2000 514 WALLACE JAMES 4b. City, Town, or Location of Deeth 4c. County of Death

1. Decedent's Neme (First, Middle, Last) 3. Time of Death **Physician** WILLIAM pm /Medical 4e Fecility Name (ff not institution, give street and number) Examiner Coty Maryland General

5. Social Security Number | 6. Sex Hospital 8. Dete of Birth (Month, Day, Year)
SEPT. 25/924 S. Carolina Age (In yrs. last birthday) If Under 1 Ye **Funeral** Deys Months Hours DOM 20 F 76 250-20-8223 Director Usuel Residence of Decedent Manyland 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits BALTINOR 1 Yes 2 No Director Mary And Number if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23s or 28s-f other traumstic event, the Medical Essentian must be notified 10g. Citizen of What Country? 10f. Zip Code 2837 Waldorf Avenue 2/2/5 U5 1 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1. B√7es 2 □ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Meritel Stetus Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: Jack by 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Bethleham Steel Elementery/Secondery (0-12) College (1-4or 5+) 11th grade Steelworker 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) WILL WOODWAYD Jannie Byro)illiam 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Waldorf Avo BAIL MOVE, Mary mo 21215 2837 Wallace Madys 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State permit. Peges 1 Department of H Important: If its any injury or ot Burial 2 Cremation 3 Removel from Stele
4 Donetion 5 Other (Specify) Juings Mills, mu Forst Veteran Cimekas 22. Name and Address of Facility CHATAN AN - Nursels XIV. 21. Signeture of Funeral Service Licenses 5240 REISTE ROBUM RNH: HUX, Mary low retour kens 23a. Pert1. Enfer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart teilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Due to (or es a consequence ot) Physician/Medical Examiner lew requires that the death certificate be axecuted Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last and bro vascular attending physician for use as the burial P.O. Box 68760. Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. been signed by the s should be detached 1 Yes 2 No 3 Probably 4 Unknown à Division of Vital Records. 24b. Were autopsy tindings available prior to completion of cause of deeth? Completed 24a. Was an eutopsy page 2 : The 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Wes case referred to medical 26. Place of Deeth (Check only one) Be Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No this After this funeral of 28c. tnjury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Injury 1 Neturel after death. Director: After d in by the fur 1 Tes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, term, street, tectory, office building, etc. (Specify) 4 Homicide ithin 24 hours at o the Funeral Di ompletely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. edicai 29e. Certifier 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number

State

Registrar DHMH 16 Rev 6/95

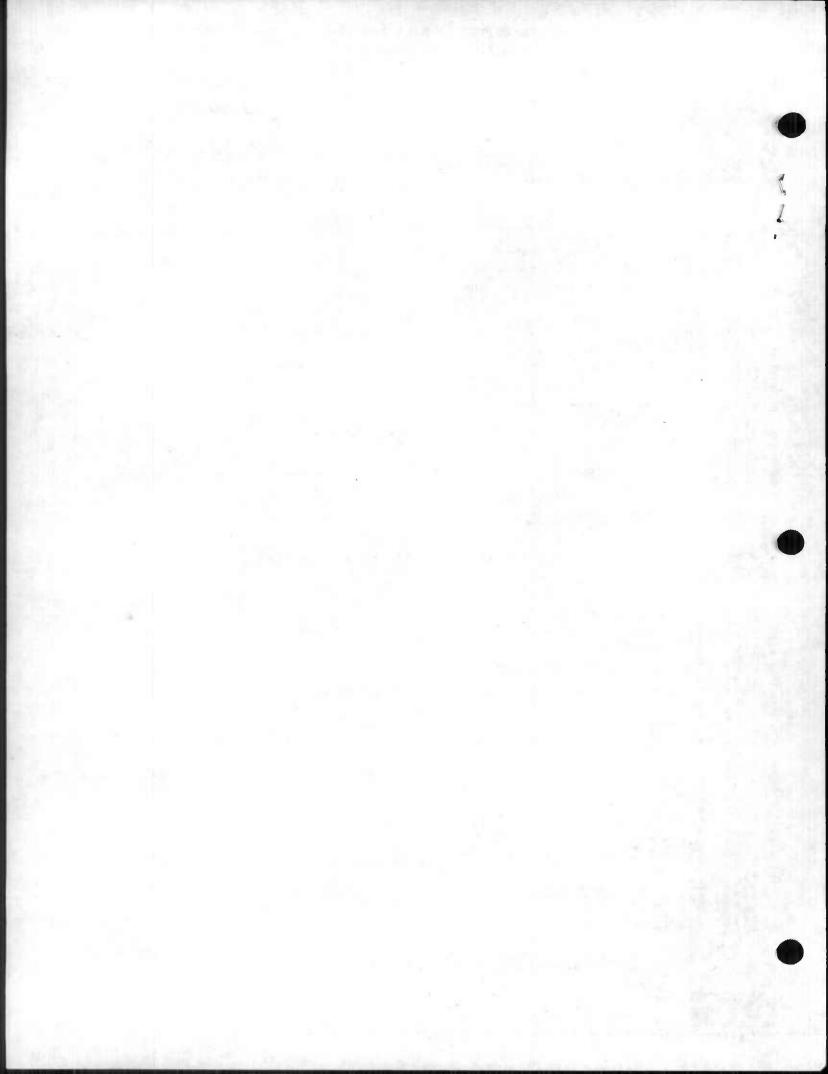
m.D. 40 (40MG Junhui 31. Date tiled (Month, Dey, Year) JAN 2 0 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

maryand 32. Registrar's Signeture Lycardon ORIGINAL

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29/2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadent's Nama (First, Middla, Last) 2. Data of Death **Physician** Yaar 2000 rsena 10 /Medical (Facility Nama (If not institution, give street and number) City, Town, or Location of Deeth 4c. County of Death Examiner 11 If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 09/17/1916 orsica If Undar 1 Year 5. Social Sacurity Number 6. Sex Birthplaca (State or Foreign Country)
 ILLINOIS 7. Aga (In yrs. last birthday) **Funeral** Months Days 1□M 2XF 84 Yrs Director 327-01-3284 Usual Rasidance of Decedant the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28s-1 shov traumstic event, the Medical Exemples result be notified at 1 ☐ Yes 2 No QUEEN ANNE'S CHESTER Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 2815 COX NECK ROAD 21619 U.S.A. Funeral 72 hours after death 12. Was Decedent Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indien, Black. Whita, atc. 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Datas: 1 Nevar Married 2 Married Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: by Specify: WHTTE 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) ACCOUNTANT ACCOUNTING 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maldan Surnama) Be should be fand Mental F P MICHAEL RADAKOVICH SAVA TRKULJA 19a. tnforment's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Department of Health a Important: If Itam 27 is any injury or other tra 2815 COX NECK ROAD CHESTER, MARYLAND 21619 ELI DABICH, JR. / SON Baltimore, 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 IX Cramation 3 ☐ Ramovai from State 4 ☐ Donation 5 ☐ Othar (Specify) CHESAPEAKE CREMATION CTR. 1/5/01 21. Signature of Funeral Sarvice Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 106 SHAMROCK ROAD CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications in treaused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one ceuse or each line. Approximata Intervel Betw **Physician** /Medical tmmediate Cause (Finel disaasa or condition rasulting In daath) Meumonia **Examiner** Dua to (or as a consaguanca of): Examiner Sequantially list conditions, if any, leading to immadiate causa. Entar Undarlying Ceusa (Disaasa or Injury thet initiated avants rasulting in death) Lest Dua to (or as a consaguanca of): Box 68760. attending physician for use as the buna Physician/Medical Dua to (or as a consequence of) ed by the a Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco usa contribute to the cause of death? o signed by t 1 Yes 2 No 3 Probably 4 Unknown 0 þ Division of Vital Records, 24b. Were eutopsy findings availabla prior to completion of causa of daath? Completed 24a. Was an eutopsy performed? The law cartificate has 1 Yas 2 Tho 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this cartific. Be 25. Was casa rafarred to medice! axaminar? 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) Certification: To 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Deta of tnjury (Month, Day Yaar) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Panding invastigation 1 Accidant 1 ☐ Yas 2 ☐ No 6 Could not ba 3 Suicida 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 28a. Place of injury - At homa, farm, streat, factory, offica building, etc. (Specify) 4 Homloida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the causa(s) and mannar es steled.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and mannar stated. 29a. Cartifiar Medical (Check only one) 29b. Signatura and title of certifier 032036 1/1/2001 30. Name end addrass of person wholcomplated causa of death (Item 23a) (Type, Print) Druis Checker M.) 21619

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32. Ragistrar's Signature

State Registrar

31. Data filed (Month, Day, Year)

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DHMH 16 Rev 6/95

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OFFICE PROPERTY OF FRANCES

Physician /Medical			Reg. No. 00 43531								
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/Medical Examiner	4e Fecility Neme (If not institution, give		Jr.		4b. City, Town, or Lo	DEC ocation of Death		2000 5:00a.			
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Funeral Director	211 21 2000	ex 7. Age	(In yrs. last birt	hday) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day N II V	1926	9. Birthplace (State or Fore Country) MD			
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	10e. Street and Number	11	WESE	10f. Zip Code			10g. Citizen of V	What Country?			
	89 W. Sunshine	Way		21	157		usa				
	11. Meritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ev Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Detes:		13. Wes Decedent of If Yes, specify Cul		ecify Yes or No- Rican, etc.)	14. Rac Bled Specify	e - American Indien, ck, White, etc. .: White			
Q D	15. Decedent's Ed		Decedent's Usual Occu	nation		16h Kind of Bu	usiness/Industry				
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traumatic event,	19a. Informant's Name/Relationship (7			Meiling Address (Stree	t and Number or Flura	al Route Numbe	or, City or Town,	Stete, Zip Code)			
	Marian Constant	ine/wife		w. sunsh	ine Way						
or other	20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town										
	4 Donetion 5 Other (Specify) Druid Ridge Cemetery 12/30/2000 Pikesville,										
any injury poce.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home and Chapel										
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BEC 28 1800 James & 1800 8 5 330

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. AMEND ITEM: #23 PART I, PER State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Dete of Death 1 Decedent's Name (First Middle Last) 3. Time of Death Month November 6,2000 **Physician** LEONARD CHARLES DAVIS 0130 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Neme (If not institution, give street and number) Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO ff Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth | Months | Devs | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months 128 M 2□ F 260-72-1332 Yrs. September 6,1947 Georgia **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Delaware Sussex Selbyville 1 ☐ Yes 2 ☒ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 19975 USA 238 214 Mallard Lake Funeral 14. Race - American Indien, Bieck, White, atc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) or hama 11. Merital Stetus 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: White 3 Widowed 4 Noivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elemantery/Secondary (0-12) Collega (1-4or 5+) Chaillet-Nichols Inc. 12 Carpet Technician 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 1 and 2 should be fit Health and Mental H tem 27 is merited oth Bonnelle Leonard Davis Lancaster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) . Judy L. Gorman/Girlfriend 214 Mallard Lake, Selbyville, DE 19975 If Nam 27 h 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriel 2 ØCremetion 3 ☐ Removel from Stete 11/8/00 Salisbury, MD Salisbury Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Holloway Funeral Home Professional Association M01051 501 Snow Hill Rd., Salisbury, MD 21804 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haert failure. List only one cause on each line. Approximete tntervel Batween Onset end Death Physician Immediate Cause (Final disease or condition rasulting in deeth) /Medical Examiner SEPSIS PINGUNOUIA Physician/Medical Examine Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events PNEUMONIA WITCH CORORAL HELLORIHAC Due to (or es e consequence of) INTRACEREBRAL HEMORRHAGE Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 nknown RENAL FAILURE ρ Be Completed 24b. Were autopsy findings 24a. Wes en eutopsy performed? eveileble prior to complation of cause of death? page 2 1 Yas No 2 X No this certificate 1 Yes of Vital or Attending Physician: 25. Was case referred to medicat examinar? 26. Placa of Daath (Check only one) Other: 4 Nursing Home 5 Rasidenca 6 Other (Specify) 1 Yes 2 No edical Certification: To 1) Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28b. Tima of 28c. tnjury at Work? 28d. Dascribe how injury occurred Division 1 Natural 2 Accidant 5 Pending investigation after death. 1 Yes 2 No 3 Suicida 6 Could not be 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Streat and Number or Rurel Route Number, City or Town, Stete) 4 Homicide within 24 hours of To the Funeral I Certifying Physician: To the best of my knowledge, deeth occurred et the tima, date and place, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, daeth occurred et the time, dete end placa, and due to the cause(s) end mannar stated. 29a. Certifier 29b. Signeture and little of certifier 29d. Dete signed (Month, Dey, Year) 29c. License number 30. Name and address of person who completed cause of deeth (Itam 23a) (Type, Print) DR. SVITE A102 560

Registrar

32. Pagistrar's Signature

30108200 James & Johnson

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

AMEND Amende	ITEM: #10E , 26 PER Sta d #26, 1/2/01, cwc, Ke	te of Maryland/ nt County	Department of F 24-01 WR Certificate of	lealth and M Death	lental Hygie		43	533
Physician /Medical	1. Decedent's Nama (First, Middle, Last) Mildred		Davies		2. Data of Death Month December	Day 24 2	Yaar 2000	3. Tima of Death
Examiner	4a Facility Neme (If not institution, give street e The Kent and Queen Ar			4b. City, Town, or Lo Chestert		4c. County Kent		
Funeral Director	5. Social Security Number 6. Sex 1 M 2	7. Age (In yrs. last	birthday) If Under 1 Year Yrs. Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You January 9,	1911 F	9. Birthplac Country allstor	ce (State or Foreign n), MD
anyland ahow	Usuel Residence of Decedent 10a. Stete 10b. County	10c. City, To	own or Location				10d	. Inside City Limits
with the Maryland a or 28a-f show the notified at Director	Maryland Kent 10e. Street and Number	Che	stertown 10f. Zip Code		10g.	. Citizen of W	Vhet Country	1X Yes 2 □ No
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d 2 should be file th and Mental Hy 7 is marked othe traumatic event	19e. Informant's Name/Relationship (Type, Pri		9b. Meiling Address (Street					ode)
CHNF	H. Morris Davies, Jr. 20e. Method of Disposition	20b Place	1257 Front St of Disposition (Name of			MD Z1		n, State
Pagent: H	1 XBurial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donetion 5 ☐ Other (Specify)	from Stata	reen Cemetery	2/28/2000 Longreen, MD			MD	
permit. Pages 1 a Department of Her Important: if item any Injury or othe page.	21 Signature of uneral Service Licenses 22. Nama and Addrass of Fecility Fellows, Helfenbein & Newnam Funeral Home 130 Speer Road, Chestertown, Maryland 216							
certificate be executed ding physician and use as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest	Due to (or as	e consequenca of): a consequenca of): a consequence of):					
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To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificat completely filled in by the funeral director, p. Medical Certification: To Be Co.	2 Accident investigation			Yes 2 □ No	28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)			
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To the within To the compl	29b. Signeture end title of certifier WBB Lensha	m, M.O.		35779	0		ben	27,2000
	30. Name and address of person who complete W. BNULO OLENSA	d causa of deeth (Item 23	a) (Type, Print) S. Bohemi	a Heve., C	Lecilton	, mo	1.21	917
State Registrar	31. Data filed (Month, Day, Year) JAN 0 2 200	32. Registrar's Signature		A.				

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State of Maryland / Department of Health and Mental Hygiene 0 43534

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/Medical	Catherine E. For	der					1 29,	2000 +	35
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Annual Hygiene. Its event, the Medical Examiner must be notified To Be Completed by Funeral Director	, , , , , , , , , , , , , , , , , , , ,	re							
	10e. Street and Number 3804 Coolidge Av	ve.	21229				United States		
	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yas 2 ☒ No If Yes, Giva 1 ☐ Yas 2 ☒ No Specify:			Specify Yas or No- to Rican, atc.)				
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Within 24 hours after death. To the Funeral Director: After to completely filled in by the funer. Medical Certification:	29e. Cartifier (Check only one) 17 Certifying Physical Examin	Iclan: To the best of my ker: On the basis of exami and mannar stated.	nowledge, deeth on nation and/or investigation	ccurred et tha ti	me, dete end plece opinion, deeth occi	s, end due to the durred at tha tima, d	ause(s) end me late and placa,	nnar es stated. and due to tha caus	sa(s)
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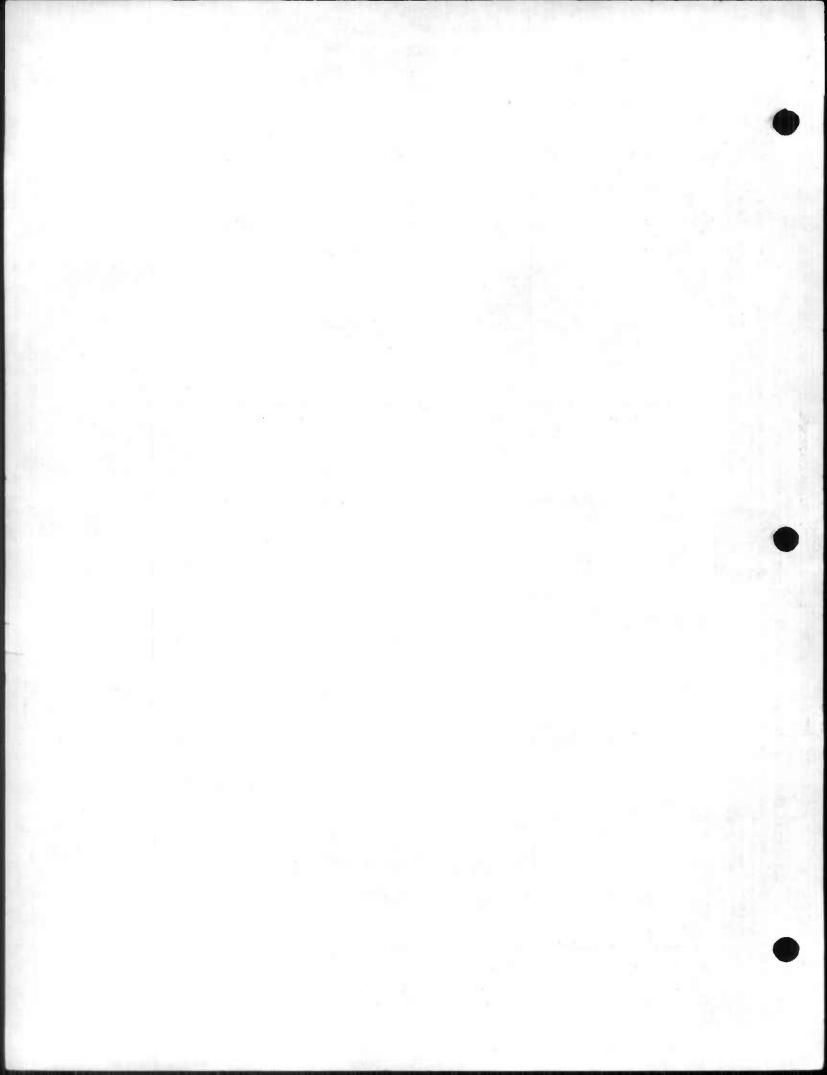
JAN U 3 2011 January & march

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AMEND FIFM: #23 PART I, PER PHY G781 1-24-01 WR. Certificate of Death

State of Maryland / Department of Health and Mental Hygiene
Req. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 4:05 AM RUTH SEPT. 2000 NAOMI GRAHAM 16 /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WICOMICO ATRIA ASSISTED LIVING SALISBURY 8. Dete of Birth (Month, Dey, Year) JUNE 20, 1915 If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country)
 MARYLAND 7. Age (In yrs. last birthday) **Funeral** 1□M 2♥F Months Deys Hours Min. Yrs. Director 85 212-09-7719 Usuet Residence of Decedant 72 hours efter deeth with the Maryland x 28a-f ahow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director MARYLAND WICOMICO MARDELA SPRINGS 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code Examiner must be 21837 109 BACON ST. U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Meritel Stetus Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: Specify. by 3 N Widowed 4 Divorced WHITE d be filed within 72 hours antal Hygiene.
ced other than "nature cevent, the Medical E. Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. POSTAL SERVICE POSTAL CLERK 12 17. Fether's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be 1 Departmant of Health end Mental I Important: If Item 27 fa marked of 7 is marked traumatic ev ELIZABETH E. WILKINSON S. ROLAND HENRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 125 WALNUT DR. SEAFORD, DE 19973 JANET G. OWENS - DAUGHTER item 2 20e. Method of Disposition 20b. Ptece of Disposition (Name of cemetary, cremetory or other place) Dete 20c. Location - City or Town, Stete Important: if it any injury or o 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) MARDELA MEMORIAL CEMETERY 9/23/00 MARDELA SPRINGS, MD 22. Neme end Address of Fecility 705 E. MAIN ST. durtho 1 BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804 Approximata Intervel Between Onset end Deeth 23a. Part1. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errast, shock, or heart feilure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) VASCULITIS 6 MOS. Examiner Dua to (or as a consequence of) CHF Examine attending physician end for use as the burial-transit Sequentially list conditions, if any, leading to Immediata cause. Entar Undarlying Couse (Disease or Injury that initiated evants resulting in death) Last Dua to (or es e consequenca of): **Physician/Medical** Due to (or es e consequence of). P.O. ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by i 1 Yes 2 No 3 Probably 4 Unknown The law requires that CHF Records. þ page 2 should 24b. Wara autopsy findings Be Completed 24a. Wes an autopsy performed' completion of cause of death? 1 ☐ Yes 2 No 1 Yes 2 No of Vital Physician: 25. Was case referred to medical axaminar? 26. Place of Death (Check only ona) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this 28a. Date of tnjury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred Attanding Division 1 Neturat 2 Accident 5 Pending investigation 1 Yes 2 No deeth. after deeth 3 Suicide 6 Could not be detarmined 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \ Homicide ò To the Hospital within 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred at the tima, data end place, and due to the cause(s) and mennar as stated.

| Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted. Medicai 29e. Certifier (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signeture and this of certifier 29c. License number SEPTEMBER 18, 2000 D26612 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 10 105 PINE 32. Regional Signature MICHAEL E. CROUCH, MD SALISBURY, MD 21801 sporks State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death AMENDED ITEM #23a per phys G791 012301 SS 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day 2 Jones November 2000 10:20AM Grace 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death College View Center Frederick Frederick 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) Months Davs Hours 1 □ M 200 F Yrs. 91 1909 218-50-4051 Jan. 19, Washington DC Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 Yes 2 No Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21701 U.S.A. 700 Tollhouse Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates: 14. Raca - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Nevar Married 2 ☐ Married 1 Yes 2K No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Elementary/Secondary (0-12) Cottege (1-4or 5+) 11 homemaker own home 18. Mother's Neme (First, Middla, Maidan Sumama) 17. Father's Name (First, Middla, Last) Margaret Butler Eppa C. Royston 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) Philip Geraci - son 7 Winifred Ct., Burtonsville, MD 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. 6 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) nr. Libertytown, MD 2000 Central Cemetery 21. Signature of Funerat Service Licenses 22. Nama and Address of Facility Hartzler Funeral Home 11802 Liberty Rd., Libertytown, MD arise 23a. Part1. Enter the disease, or complications that cause of the Ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata tntervat Between Onsat and Daath Aspiration Immediata Cause (Final disaasa or condition resulting in death) MEI Due to (or as a consequence of): years wee COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting In death) Last Due to (or as Dua to (or as a consequence of): 23b. Dtd tobacco was contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Physician /Medical Examiner

attending physician and for use as the burial-transit certificate be executed

signed by t

page 2 s hes

After this

Director

Physician/Medical Examiner

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Completed

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Medical Certification: To

State Registrar

Physician

/Medical

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Funeral

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permit. Pages 1 and 2 should be filed within 72 ht. Department of Heelth and Mental Hygiene. Important: If Itam 27 Is marked other than "natur. any injury or other traumatic avent, the Medical once.

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the Maryland

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Baltimore, Maryland 21215-0020

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1 Yes 20No 3 Probably 4 Unknown

24a. Was an eutopsy performed?

24b. Were autopsy findings available prior to complation of causa of death?

2 DANO

1 ☐ Yas 2 ☐ No

25. Wes case referred to medical examiner? 1 Yas 2 No 27. Menner of Death

1 Inpatient 28a. Dete of injury (Month, Day Year) 5 Pending investigation

Hospital:

2 ER/Outpatient 3 DOA 28c. Injury at Work?

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

26. Place of Deeth (Check only one)

Other:

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 | Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated.

29b. Signature and the of certifie

29c. License number

112201

29d. Date signed (Month, Day, Year)

11-3-2000 Lloyd Halvorson

30. Name and address of person who complated cause of death (Item 23a) (Type, Print) 1475 Towney Ave Suite 204 Frace Frederic

31. Date filed (Month, Day, Year)

32. Registrar's Signature

NOV 0 8 2000

6 Could not be determined

DHMH 16 Rev 6/95

ORIGINAL

Division of Vitai

The law requires that

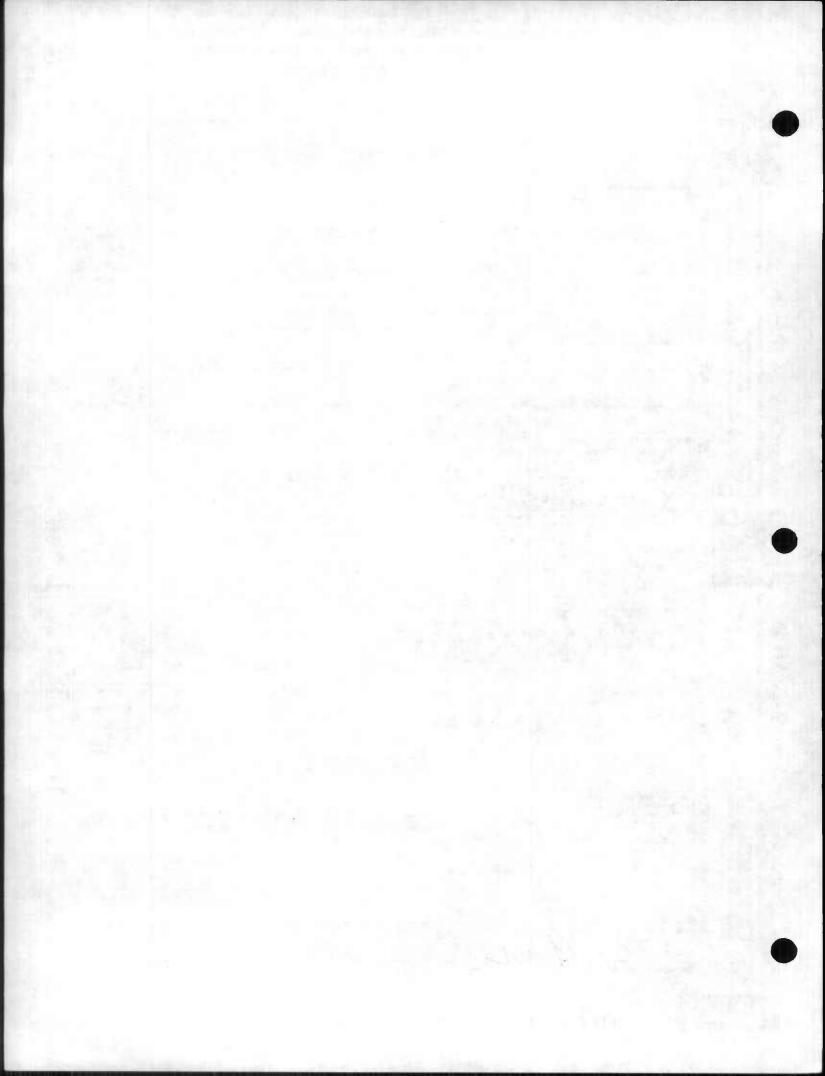
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Hospital of 24 hours at Funeral D

To the Hosp within 24 hor To the Fune completely fi



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Time of Death Month Year Physician DECEMBER 31, 2000 Helen Ruth Kahl 1420 /Medical 4e Facility Neme (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Sacred Heart Hospital Cumberland
If Under 24 Hrs. | 8 Date Allegany If Under 1 Year 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Months 1□ M 2₩ F 76 Yrs June 16, 1924 Director Maryland 577-34-6447 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or liams 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director Friendsville Garrett 94 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 161 Selby Road 21531 USA Funeral 72 hours after death 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 Ø No If Yes, Give Year or Deles: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Rece - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2√ No Specify: White Specify: Aq 3 Widowed 4 □ Divorced tal Hygiene. d other than "natura event, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grede completed) filed within Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) 2 should be fi h and Mental H he marked off 88 Clarence Earl Schroyer Iva VanSickle 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Pages 1 and 2 ament of Health an permit. Pages 1 and 2 Department of Health a Important: If Item 27 is Melvin G. Kahl/Son 297 Gravelly Run Road, McHenry, MD 21541 Baltimore, 20b. Placa of Disposition (Neme of cametery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremation 3 ☐ Removel from State 0 4 ☐ Donetion 5 ☐ Other (Specify) Blooming Rose Cem., Jan 2, 2001 Friendsville, MD 22. Nema and Address of Facility
Newman Funeral Homes, P.A., 179 Miller Street woode P.O. Box 275, Grantsville, M

23a. Part Eruer the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.O. Box 275, Grantsville, MD Approximete tntervel Between Onset end Death Physician Immediate Ceuse (Finel disaese or condition resulting in deeth) /Medical SIFEOME Examiner Due to (or es a consequence of) Examiner the death certificate be asscuted burial-tran Sequentially list conditions, if eny, leeding to immediate cause. Enter Undarlying Cause (Disease or injury Due to (or es a consequence of) pue igned by the ettending physician be detached for use as the buria Physician/Medical thet initieted events resulting in deeth) Last Dua to (or as a consequance of): 80 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown signed by thet by The law requires 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? plnous Completed Deed this certificate has page 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 1 Yes 20 of Vital Physician: director. Be 26. Place of Deeth (Check only one) Hospitel: 1 npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 28 No luneral 28d. Describe how injury occurred 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of After Attending 1 Naturel 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No al or Attandi s after death. I Director: A id in by the fu 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, atc. (Specify) illed in by 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral Discompletaly filled is 12 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. edicai 29a. Certifier (Check only one) 29b. Signeture and title of certifier 29d. Data signed (Month, Day, Year) 29c. License number WERK

State

30. Name and eddress of person who completed ceuse of death (tem 23a) (Type, Print) 902 ROBERT WELIK M.D.

SETON DRIVE CUMBERLAND, MD 21502

31. Dete filed (Month, Dev. Year) JAN - 4 2001 Registra

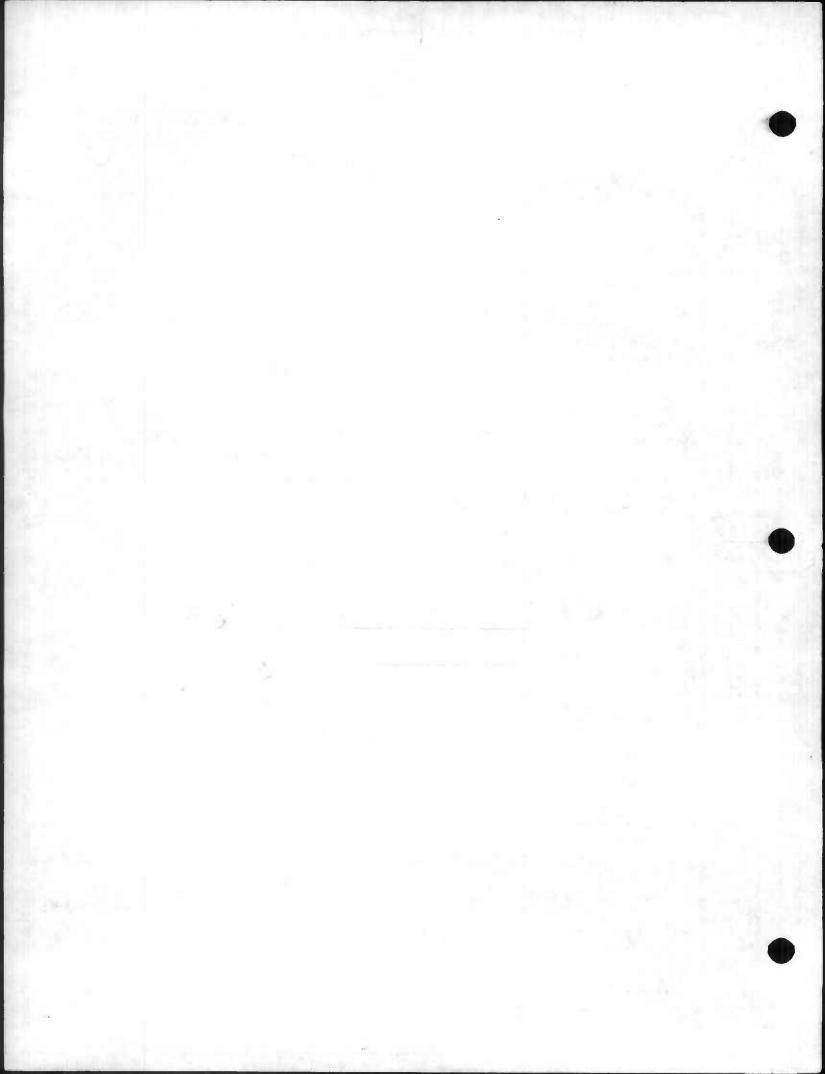
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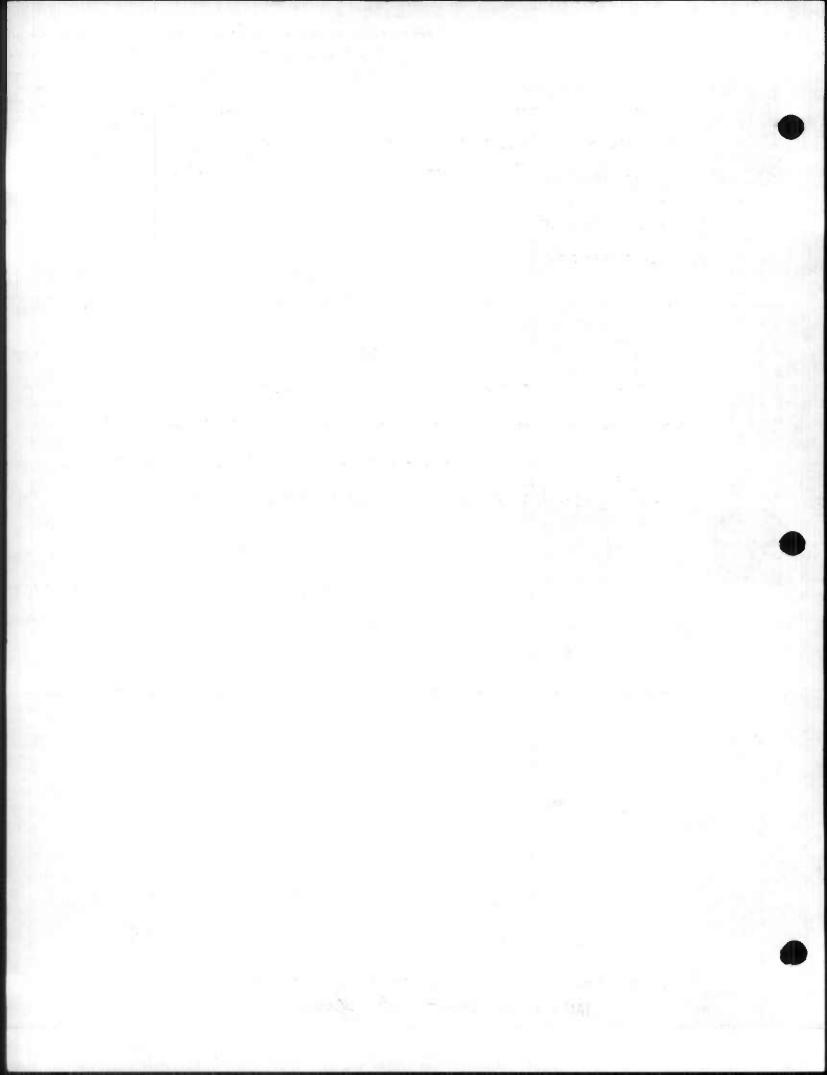
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			Hospital			William A Van	Easton			lbot	
r 2	Social Security Nut. 17-14-80()6	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yr.	82 Yrs.	Months Days	If Under 24 Hrs Hours Min		ey, Year) 18	9. Birti Co. MARY	npleca (Stete or Fore untry) 'LAND
-		10b. County	/	10c. C	City, Town or Loc	ation					10d. Inside City Lim
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Director	De. Street and Num	-				10f. Zip Code			10g. Citizen	of What Co	untry?
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nonel distance	Elamantery/Secon			(1-4or 5+)			d)		EDUC	ATTON	
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	SAMUEL J.					ROUSE RO		NSTOWN,			
-	a. Method of Dispo	sition			Placa of Dispos			Deta			Town, Steta
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edical Examiner	isease or condition sculling in deeth) equentially list con- any, leading to imr. ause. Entar Undarl ausa (Disaasa or ir hat initiated events sculling in daath) La	ying ijury	a	PARAPLE CYCO	(or as a consequ	embol	ism_				hours weeks
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2	9a. Cartifier 1 (Check only 2 one)	Certifyle	ng Physician: To the Examiner: On the and me	na best of my kr basis of exe <i>m</i> ir inner stated.	nowledga, daath nation and/or inv	occurred at tha tilestigation, in my o	ma, data and place pinion, daath occ	e, and dua to the urred at tha time	a causa(s) and , date end pla	d manner as ce, and dua	stated. to the causa(s)
2	9b. Signature and ti	tle of certifie	er a/			29c. Licens	se number		29d. Date si	gned (Monti	h, Dey, Year)
	Xax	Klee	1 40e	4		D47	627		9-	17- (00
30). Neme and address	ss of person	who complated car	use of death (Ite	om 23a) (Type, F	1 1.		C- C		4	MD 21



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-		Decedent's Neme (First, Middle	(and)		Cen	ificate of	Death	1001110	Reg. No.		3539
Physici		EVA	MAY		LEWIS			2. Dete of De Month DEC	Day	Yeer 2000	3. Time of Deeth 10:55 PM
/Medic Examir		4e. Fecility Name (If not institution,	give street and number;				4b. City, Town, or I				10.55 111
Funerai Director		314-94-7739		e (in yrs.	CENTER last birthday)	If Under 1 Year Months Days	DENTON If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, De	CARO th by, Year) 4, 1897	9. Birthple Countr	ece (Stete or Foreig y) 'LAND
and *		Usuel Residence of Decedent 10e. Stete 10b. County		10c City	y, Town or Loc	ation				10	d. Inside City Limits
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r 28s	Directo	MARYLAND CARO	LINE_	U	ENTON	10f. Zip Code			10g. Citizen of \	Whet Countr	ry?
h with		811 MARKET ST	TREET			216	29		USA		
72 hours efter deeth with the Maryland "naturel", or frems 23s or 28s-f show social Examiner must be notified	by Funeral	11. Maritel Stetus 1 Never Married 2 Merrie 3 X Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 H If Yes, Give Yeer or Detes:		If	as Decedent of H Yes, specify Cub	dispenic Origin? (Si an, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	14. Rac Blee Specify	e - America ck, White, e	
	Completed	15. Decedent (Specify only highest Elementery/Secondery (0-12)	s Education grede completed) College (1-4or	5+)	(Give k life. D		during most of wor d)	king	16b. Kind of B	usiness/Indu	
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should nd Mer marks umatic	10	19e. Informent's Neme/Relationsh			19b. Mellind	Address (Street	end Number or Ru	rel Route Numb		Stete. Zip (Code)
nd 2		DOROTHY B. LEW		-TN-T.							
of Hac		20e. Method of Disposition		20b. P	lece of Dispos			Date	20c. Location -		
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/Medical Examiner		Immediate Ceuse (Final disease or condition	N	1900	caldi	0/ /1	forct	1100			1 das
	4	resulting In death)		Due to (o	r as e consequ	ence of):	,			į.	27000
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s daath he attar led for u	sici	Pert II. Other significant condition	e contributing to death b	ut not resu	ulting in the und	lerlying ceuse giv	ven in Pert t.	23b. Dld	tobacco uss co	ntributs to	the cause of death
v requiras that the daath cer been signed by the attandin should be detached for usa	by Phy							10	Yes 2□No	3 □ Probe	ably 4 Unknow
law requiras las been sign a 2 should be	Completed								en eutopsy ormed?	com	e sutopsy findings leble prior to pletion of ceuse eeth?
siclen: The law s cartificate has b director, page 2 s	Cor							10	Yes 2 No	10	Yes 2□ No
ysiclan: is cartific director,	Be	25. Wes case referred to medical exeminer?	Hospitel:			100	26. Plece of Dee		-		
al call	tion: To	1 Yes 2 No 27. Menner of Deeth 1 Naturel 5 Pending investigs	28e. Dete of Inju	ry	ER/Outpatient 28b. Time of Injury	28c. Injur Wor	Nursing H		dence 6 Oth how Injury occur		
To the Hospital or Attending F within 24 hours efter death. To the Funeral Director: After completaly filled in by the funer	Certification:	3 Sulcide 6 Could no 4 Homloide determin	ot be One Place of Ini	ury - At ho c. (Specify	me, ferm, stree			28f. Location (City or To	Street and Numb wn, Stete)	er or Rural	Route Number,
he Hospi in 24 hou he Funera plataly fill	edicai	29e. Certifier 1 Certifying (Check only one) 2 Madical E	Physicisn: To the best xaminer: On the basis o end menner st	examinet	vledge, deeth o ion end/or inve	occurred et the tir stigation, in my o	me, dete end plece pinion, death occu	, end due to the rred et the time,	cause(s) end me dete end plece,	enner es ste end due to t	ited. the cause(s)
Within Com	W	29b. Signeture end title of certifier	MO			29c. Licens	e number	2	29d. Date signe / Z - Z		
36		30. Name and address of person w					RYLAND 21	629			
24					oo, DEL	TOIT, III.	CI DILLID -1	0-2			



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death Month **Physician** 29, 2000 Dec. 9:20 am Khoi Nguyen /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 3208 Toledo Place Apt. T-1 Hyattsville If Under 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Days Months Hours 15M 20 F Yrs. 46 218-33-7610 Director Jan. 2, 1954 Vietnam Usual Rasidence of Dacedani 10d. Inside City Limits 10c. City. Town or Location 10a Stata 10b. County Prince George's Hyattsville 1 ☐ Yas 2 ☑ No Maryland Director 28a-1 10e. Street and Number 10f. Zio Code 10g. Citizan of What Country? Examiner must be r 20782 3208 Toledo Place, Apt. T-1 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black White, atc. 1 Nevar Married 2 Married Specify: Asian Baltimore, Maryland 21215-0036 1 Yas 2 XNo Specify: py 3 ☐ Widowed 4 ☐ Divorced 'netural', the Medical E Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) illed within Elementary/Secondary (0-12) College (1-4or 5+) Apartment Building Maintenance 12 18. Mothar's Nama (First, Middla, Maidan Sumama) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If then 27 is marked other any injury or other treumatic event t7. Fathar's Nama (First, Middla, Last) 88 Chau Nguyen Khanh Thi Tran 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 3208 Toledo Place, Apt. T-1, Hyattsville, MD 20782 Tuyet Phan/Wife 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition Jan. 2, 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 2001 Silver Spring, MD Gate of Heaven Cemetery 21. Signatura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility. Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 Dires Part Linter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, wheart failure. List only one ceuse on each line. Approximata Interval Between Onset and Death **Physician** Immediate Ceuse (Final diseasa or condition rasulting in death) /Medical Metastatic Pancreatic Cancer 2 months Examiner Dua to (or as a consequence of): Examine attending physicien and for use es the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Cause (Disease or Injury Dua to (or as a consequence of). Box 68760. Physician/Medical that initiated evants rasulting in death) Last Dua to (or as a consequence of): 23b. Did tobacco use contributs to the cause of death? ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 20 No 3 Probably 4 Unknown Division of Vital Records, P 24b. Ware autopsy findings svailable prior to been sign 24e. Wes en autopsy performed? Completed completion of causa of death? page 2 s 1 Tyas 2K No 1 ☐ Yas 2 No is certificate b Physician: 25. Was cesa rafarred to medice! Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Nasidance 6 Other (Specify) 2 1 Yas 2 No this 28a. Deta of Injury (Month, Day Year) funeral 27. Mannar of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: After or Attending 5 Pending invastigation 1 (XNetural death. 1 ☐ Yas 2 ☐ No Director: / 2 Accident 6 Could not be datarminad 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) after 4 Homicida To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end mennar as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifiar edicai 29b. Signature and titla of certifier 29c. Licanse number 29d. Data signed (Month, Day, Year) 20 D41715 01/05/01

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State

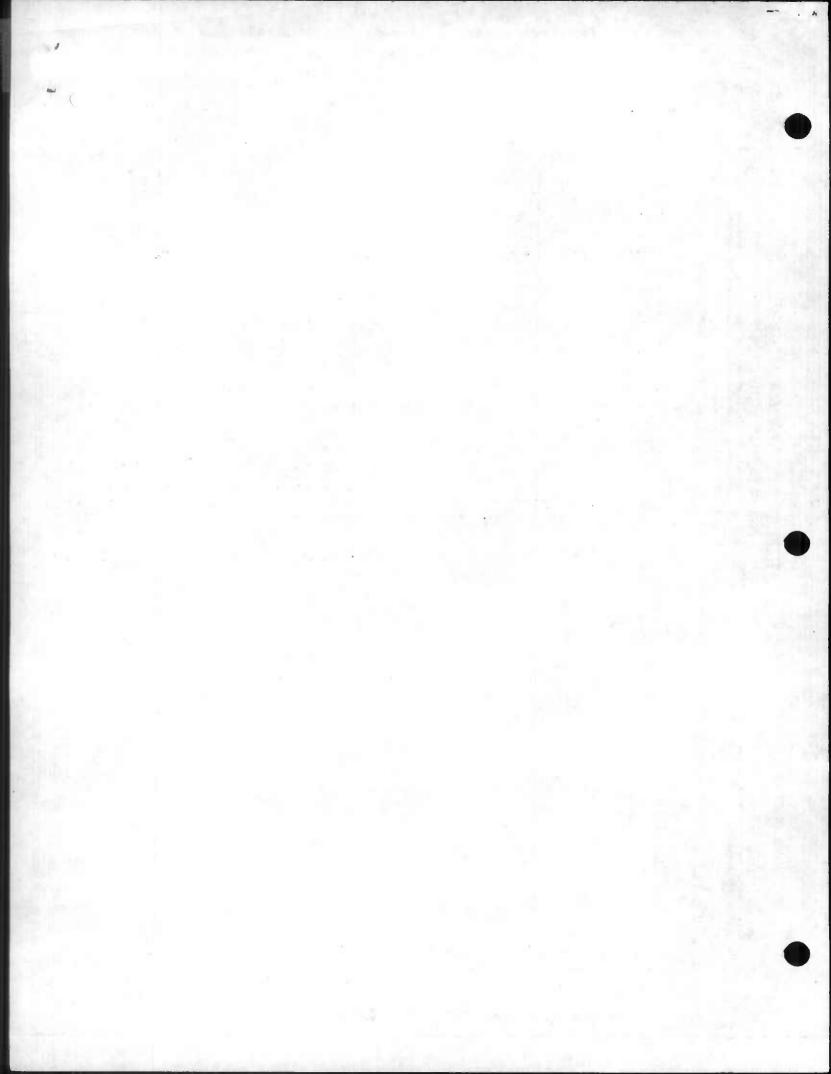
Chitra Venkatraman 31. Deta filed (Month, Day, Year)

JAN 0 8 2001

32. Registrar's Signatura

30. Name and address of person who completed ceusa of death (Item 23a) (Type, Print)

6201 Greenbelt Rd., Suite U-3, College Park, MD 20740



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

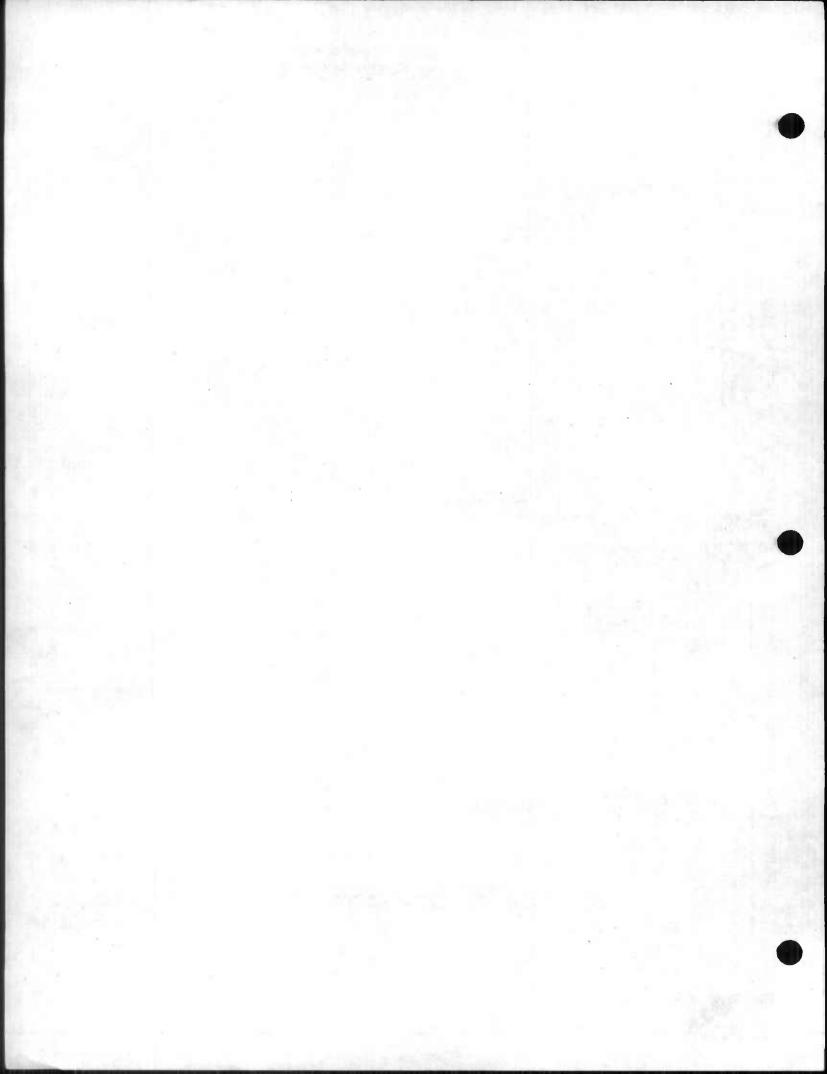
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sian	1. Decedent's Nan JACK WII			RD				П			2. Data of D Month 12	Day 31	Year 2000	3. Time of Death 7:17 PM
il r	4a Facility Name	(If not institution	n, giva street	and number)				4b. City, Tow			th 4c. Co	unty of Death	
	1414 QUE 5. Social Security		E'S DR.		ge (In yrs.	last birthday)	If Under 1	'ear	CHESTE		8. Date of B	,	EN ANN	E ' S nplace (State or Foreig intry)
ŀ	220-30-5 Usual Residence		1Ž M 2	F	6	9 Yrs.	Months D	ays	Hours	Min.	8. Date of B (Month, D 10/29/	1931		LAND
	10a. State	10b. County	ANNE'	S		y, Town or Lo	ocation							10d. Inside City Limit
	10e. Street and Nu	umber					10f. Zip Co					10g. Citizen	of What Cou	untry?
	11. Marital Status	rried 2 Man	12. W Ar 1 [as Decedent med Forces Yas 2 X Yes, Give ear or Datas:	t Ever in U, ? INo		Was Deceden If Yes, specify	ot H Cubs	lispanic Origi an, Mexican, Specify:	n? (Spe Puerto F	city Yes or N Rican, etc.)	0- 14.	Race - Amer Black, White ecity: WHI	, etc.
-	(Spe	15. Deceden ecify only higher condary (0-12)	st grade com	pleted) bliege (1-4or	5+)		dent's Usual Co kind of work of DO NOT use it ECT MAN			of workir	19	16b. Kind o	of Business/li	ndustry
	17. Father's Name	(First, Middle,	Last)						18. Mother	s Name	(First, Middle	e, Maiden Sui	mame)	
	ELMER FI					40h 14-11	ing Address (S				ESHKE	han Cibran To	Ctata 7	in Code)
	19a. Informant's PATRICIA						QUEEN					STER, N		
		Cremation		al from State	0	emetery, cre	osition (Name matory or otha	r plac		 	Data		ion - City or 1	
	21. Signature of	5 ☐ Other (S		16	1	2 F	KE CREM 2. Name and A ELLOWS, 06 SHAM	ddra H	ss of Facility ELFENB	EIN	& NEW	NAM FUI		
	Immediate Cause disease or conditi resulting in death	ion	a	30 91 5201		PANA or as a conse	veatic		can	cex	-			Interval Between Onset and Death
	Sequentially list of it any, leading to cause. Enter Unc Cause (Disease of that initiated even resulting in death)	115	c			or as a conse								
	Part II. Other sign	ificant condition	ons contributi	ing to death	but not ras	ulting in tha	underlying cau	se giv	ven in Part I.			d tobacco us		to the cause of deat
											24a. Wa	s an autopsy formed?	8	Were autopsy tindings available prior to completion of cause of death?
												Yes 201	No 1	1 ☐ Yes 2 ☐ No
2	27. Manner of Dea	No ath	Hospita 28	al: 1 Inpat a. Date of In (Month, D		ER/Outpatie		Oth	ner: 4 Nur	sing Hor		sidenca 6 De how injury o		cify)
		5 Pendir	gation		njury - At he	ome, farm, si	M treet, factory, o	10	Yes 2□N	lo	28f. Location City or T	(Street and Nown, State)	lumber or Ru	ural Routa Number,
ceimicanon. 10	1 Satural 2 Accident 3 Suicide 4 Homicide	6 ☐ Could		building, e	building, etc. (Specify) City or Town, State) tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	2 Accident 3 Suicide	6 ☐ Could determ	nined 200	building, e	t of my kno	wledge, deal						e cause(s) an		stated.

State Registrar 31. Data filed (Month, Day, Year)

32. Registrar's Signatura

Densin G. Spark

DHMH 16 Rev 6/95



Please Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** Month James Louis 31,2000 Paugh December 6:45PM /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** 106 Center Street Kitzmiller Garrett H Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) | May 20, 1925 6. Sex 1⊠ M 2□ F 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 75 Yrs. Director 218-16-4621 Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hyglena. Important: if Item 27 is marked other than "natural", or items 23s or 23s-f show any injury or other traumatic event, the Medical Exertment must be notified and once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No MD Director Garrett Kitzmiller 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 Center Street 21538 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Stetus 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Year or Dates: Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No WWII Specify: þ 3 Widowed 4 □ Divorced Completed Decedent'a Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) 12 Coilege (1-4or 5+) Buffalo Coal Co. Coal Mines 18. Mother's Name (First, Middle, Melden Sumeme) 17. Fether's Neme (First, Middle, Last) Winter Carl Paugh Christina McVicker 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Diane Paugh, daughter 106 Center Street, Kitzmiller, MD 21538 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Kalbaugh Cemetary 1/3/01 Elk Garden, WV 21. Signature of Fynerei Service Licensee, 22. Neme and Address of Facility David A. Burdo Kitzmiller, MD Burdock Funeral Home 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. wood Approximate Interval Between Onset end Deeth Physician /Medical immediate Cause (Final Cerebralvascular Accidont eavs disease or condition resulting in death) Examiner Examiner attending physician and for use as the burle-trensit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or as a consequence of): id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yss 2 ☐ No 3 Probably 4 Unknown þ cate has been sig , page 2 should b 24b. Were sutopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 8 Other (Specify) 1 Yes 2 PONO 2 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 27. Manner of Death 28e. Dete of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Netural To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stele) 28e. Piaca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5+IVA Miller DO 69 Wolf Amos Dr. Oakland, MD 21550 P. Daniel 31. Date filed (Month, Dev. Year) 32. Registrar's Signature State JAN - 4 2001 Registrar

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth **Physician** December 28, 2000 EVELYN V. POWELL 2:00AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Tincess Anne Manokin Manor omerset 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Dey, Year) 6 Sex 7. Age (In yrs. last birthday) Birthpleca (Stete or Foreign Country) 1 M 200 F Days Hours Min 91 Yrs. 215-44-6031 March 16, 1909 Maryland Usuel Residence of Decedent 10e Stete 10h County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Crisfield Director Maryland Somerset 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21817 USA 87 Somers Cove Apts. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Detes: Wes Decadent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Maritei Status 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 □ Divorcad 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Nursing Home Private Nurse 11 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be William Revelle Evelyn Johnson 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Crisfield, 19a. Informent's Neme/Relationship (Type, Print) Cynthia R. Ward (grand daughter) 27227 Crisfield-Marion Rd.-PO Box 146, MD 21817 20b. Plece of Disposition (Name of cometery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 XBurial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Sunnyridge Memorial Park 12/30/00 Crisfield, MD 21. Signature of Punerel Service Licen 22. Neme end Address of Fecility Bund leve Bradshaw & Sons Funeral Home aus. 306 W. Main St. - Crisfield, MD 21817 Robert H. Bradshaw 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death Ementia Viscular/yee Immediate Ceuse (Finei disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting In deeth) Lest Due to (or es e consequence of) Due to (or es e consequenca of): Pert IL Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 1 No 25. Was case referred to godical comminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 25€No 2 ☐ ER/Outpatient 3 ☐ DOA

Examiner

Vital

of

Division

Examiner Physician/Medical signed by the a ρ Be Completed page 2 Physician: director Certification: To this funerai After Attending death. efter death in by 6 To the Hospital or within 24 hours eff To the Funeral Di completely filled in

Funeral

Director

al', or items 23a or 28a-f show Exercises must be notified at

"natural", or

nd Mental Hygiene.

ant of Health and Mental H t: If item 27 is marked oth y or other transmiss even

permit. Pege Depertment of Important: If any Injury or once.

Physician

/Medical

filed within 72 hours after

2

Peges 1 and & should

21215-0020

Baltimore, Maryland

Other: 4X Nursing Home 5 Residence 6 Other (Specify)

27. Menner of Deeth 1 Neturel 2 ☐ Accident 5 Pending investigation

28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated.

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Dey, Yeer)

12-28-2000

50. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print)

GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR, SALISBURY, MD 21801 31. Date filed (Month, Day, Yeer) 32. Registrer's Signeture

State Registrar

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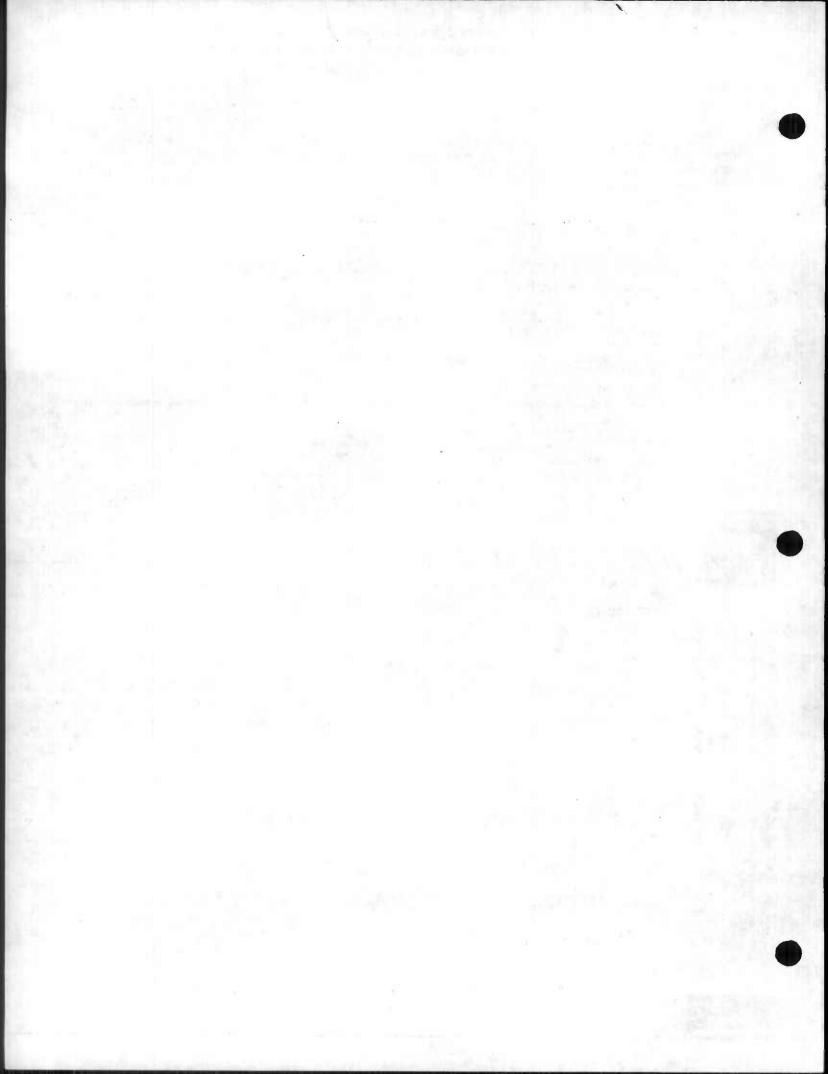
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State of Maryland / Department of Health and Mental Hygiene 0 U 4 3 5 4 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** 29, 1317 MARY VIRGINIA 2000 December /Medical 4b. City. Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, give street and number) Examiner Talbot The Memorial Hospital Easton If Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 200 F 222-14-9475 Yrs. Director MARYLAND JAN. 26,1928 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Mante r than "natural", or flerns 23s or 28s-f show the Medical Examiner must be notified at 1 Nes 2 No Directo MD OUEEN ANNE'S GRASONVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6 GRASONVILLE TERRACE 21638 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11 Merital Status 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: WHITE à 3 AWidowed 4 □ Divorced Yeer or Dates: Completed 16a. Dacedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 11 BOOKKEEPER POULTRY INDUSTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Surname, should be nd Mental is marked "UNKNOWN" IDA JOSEPHINE THOMAS To and 19a, Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) opartment of Health a Important: If them 27 is any injury 1 and 2 23621 THAWLEY ROAD, DENTON, MD 21629 BARBARA RINGGOLD/ DAUGHTER 20b. Placa of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete Pages nent of 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete MD VETERAN CEMETERY 1-3-2001 HURLOCK, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. bein womas 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each lina. Approximate Interval Betw Onset end Death **Physician** /Medical Immediate Causa (Final 3 wks neumonia disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner obstructive disco Years LYONIC certificate be executed Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the buriel-tran Physician/Medicai Due to (or as a consequence of): that the death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown cancer þ of Vital Records. The law requires 24b. Wara autopsy findings available prior to completion of ceuse of deeth? 24a. Wes an autopsy Completed page 2 this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: funeral director, 25. Was case referred to medical Be 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Annatient 2 ER/Outpatient 3 DOA 1 Yas 2 No 0 28c. Injury at Work? 27. Mannar of Death 28b. Tima of 28d. Describe how injury occurred Certification: After Attending 5 Pending investigation 1 Natural death. 1 Yes 2 No spital or Attendi ours after death weral Director: A filled in by the f 2 Accidant 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida To the Hospital
within 24 hours a
To the Funeral Completely filled **Certifying Physician: To the best of my knowledga, daath occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 30/00 30. Name and address of parson who completed cause of death (flem 23a) (Type, Print) DAVID G. OLIVER, M.D., 503 DUTCHMAN'S LANE, EASTON, MD 21601 31. Date filed (Month, Day, Year) JAN 0 2 32. Registrar's Signature State 2001 ooks Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMND ITM#5 PR. F.H. G800 10-17-01 JAB 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death LOUISE ISABELLE RENNER 12:35 PM Decembe 31 2000 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street end number) Washington County Hospital Hagerstown Washington County | If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth | Months | Deys | Hours | Min. | Sept. 26, 1917 9. Birthplace (Stata or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 1□ M 212 F 217-18-728 83 Yrs. Usual Residence of Decedant 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Washington Co. Hagerstown 1 ☐ Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1400 Oak Hill Avenue 21742 U.S.A. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S Armed Forces? 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No If Yes, Give Specify: White 1 ☐ Yes 22 No Specify. 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) Homemaker Own Home 8 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Mary Ruth Trumpower David Jesse Martin 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) 13112 Rockdale Road, Clear Spring, Maryland 21722 Jerold Oaks/Friend 20b. Plece of Disposition (Name of cemetery, crametory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete St. Paul's Cemetery Jan. 4 Clear Spring, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility
Douglas A. Fiery Funeral Home 21. Signeture of Funeral Service Licensee 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 Mikerner 23a. Part I Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haar failure. List only one cause on aech lina. Approximate Intervet Between Onset and Death (myst arcival Immedieta Causa (Final Winny yers of disease or condition resulting in deeth) actory disease wash Due to (or es a consequence of): clisa-so dependent to days to Sequentially list conditions, if eny, laeding to immediate ceuse. Enter Underlying Cause (Diseasa or Injury that initiated evants resulting in death) Lest Due to (or es a consequence of): R. myscarchel Mourtonsun Due to (or es e consequence of): Part It. Other significant conditions contributing to death but not resulting in the undarlying ceuse givan in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to 24a. Wes en eutopsy performed? completion of cause of death? 2 DINO 1 ☐ Yes 2 ☐ No 25. Was cesa rafarred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Dete of tnjury (Month, Dey Year) 28c. Injury at Work? 28b. Tima of 28d. Describe how injury occurred 1 Naturet 2 Accident 5 Pending 1 Yes 2 No investigetion 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homicide

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State Registrar 31. Date fited (Month, Day, Year)

29b. Signeture and title of certifier

D47234

Certifying Physician: To the best of my knowledge, daeth occurred at the time, date end plece, and due to the ceuse(s) end manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29d. Dete signed (Month, Day, Year)

29c. License number

mais mo 30. Name and addrass of person who completed causa of death (Itam 23a) (Type, Print)

Strayss 747 MO

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32. Registrer's Signeture

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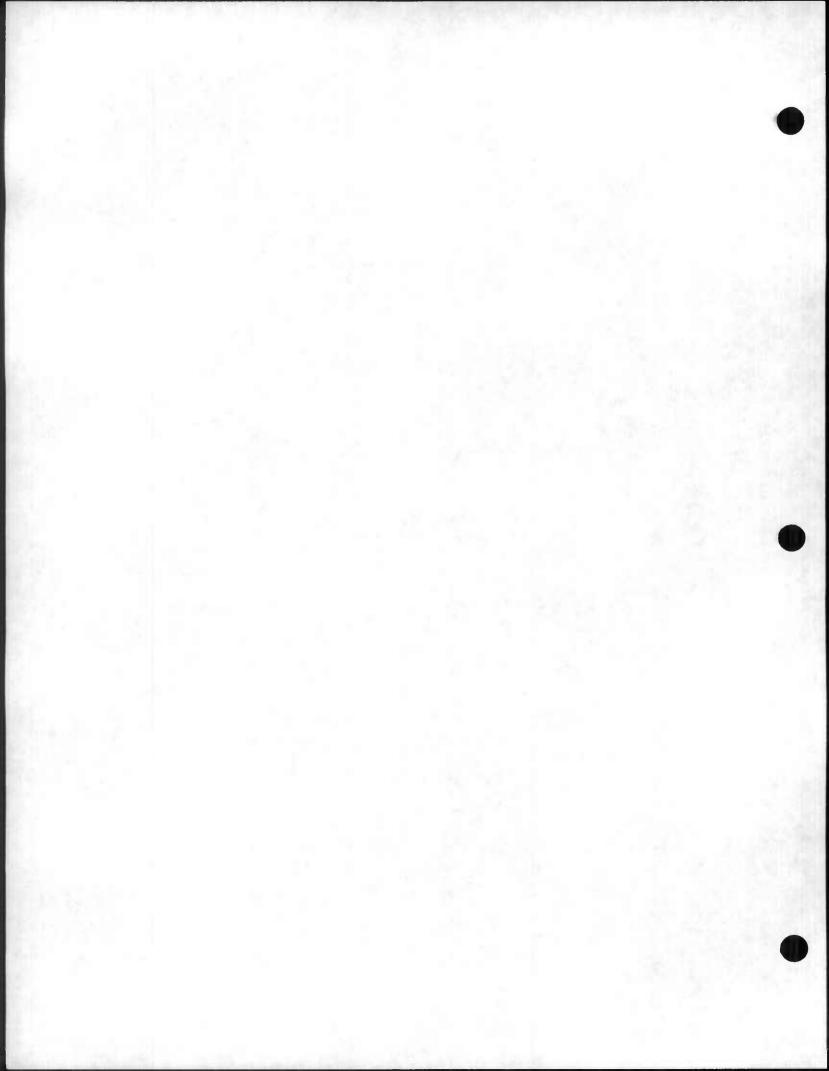
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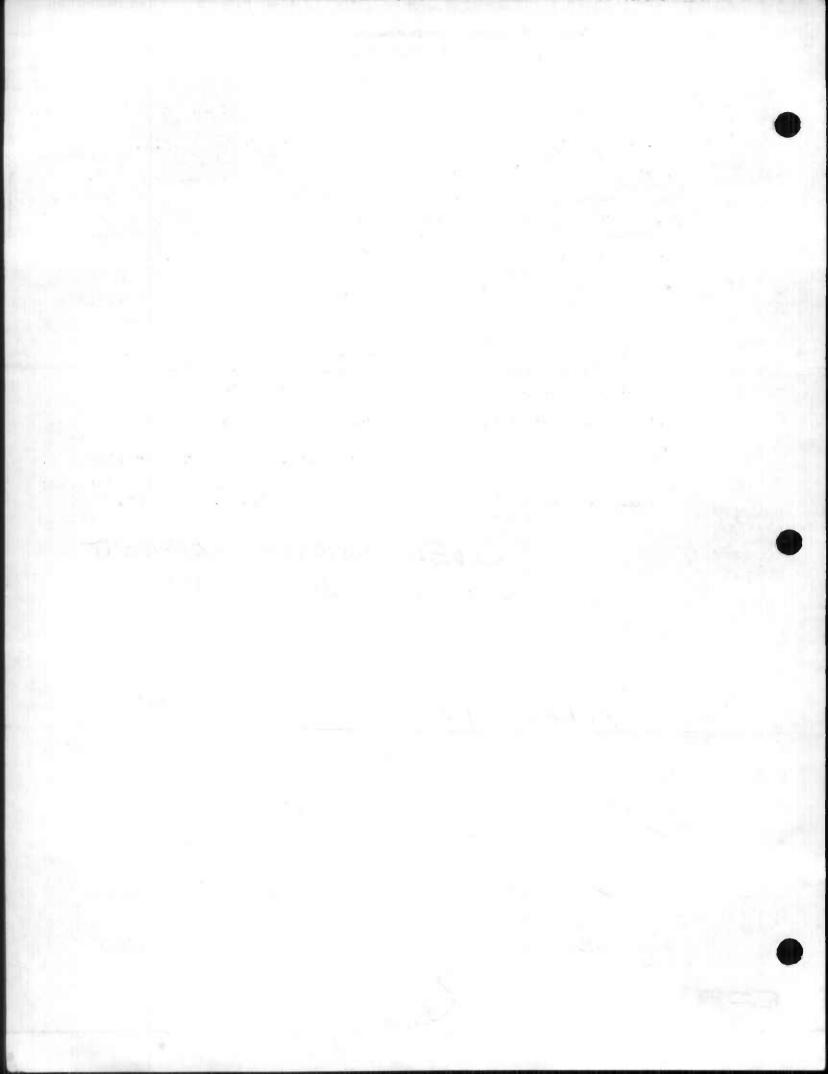


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State of Maryland / Department of Health and Mental Hygiene 1 3547

					Ce	rtificate	of Death		R	eg. No.		1041
Physiciar	ı	1. Decedant's Name (First, Middla, L.	ast)					2.	Data of Deat Month	h Day	Year	3. Time of Death
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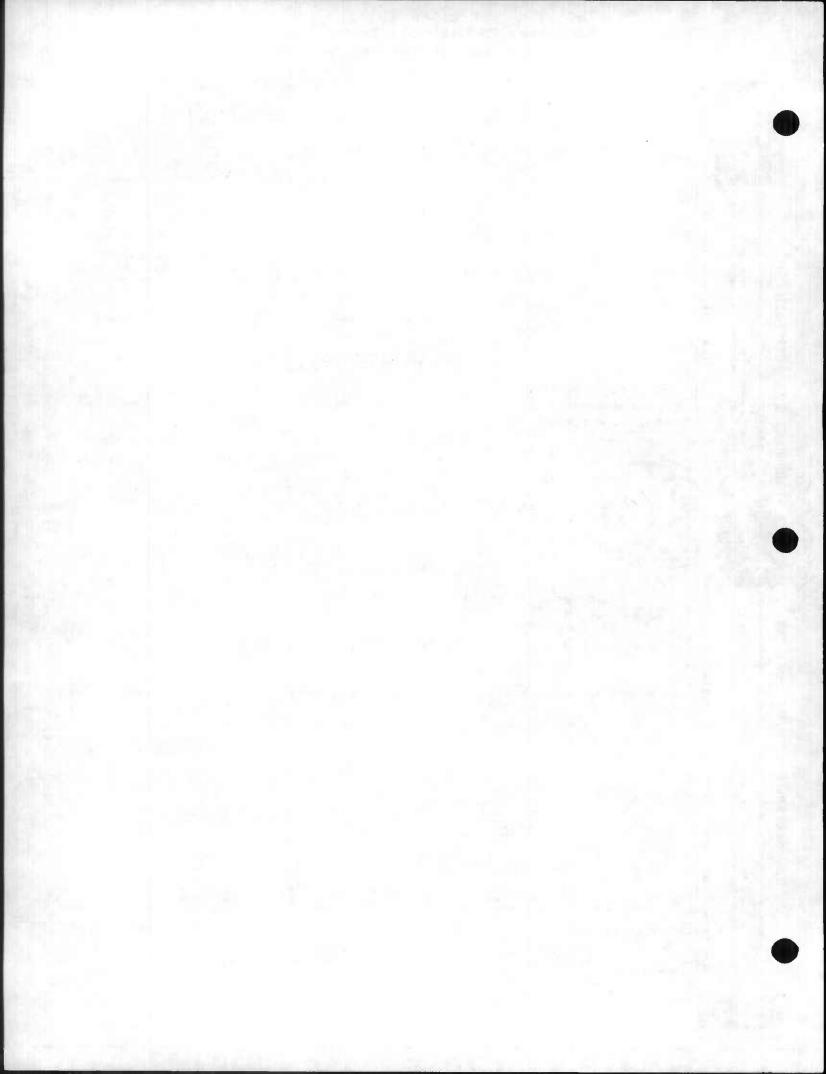


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State of Maryland / Department of Health and Mental Hygiene 00 43548

	Certificate of Death	R	eg. No.	100-10								
	1. Decedent's Name (First, Middle, Last)	2. Data of Dea Month	th Day Year	3. Tima of Death								
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200 E	10e. Street and Number 10f. Zip Coda		0g. Citizen of What C									
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265	19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street end Number or it											
27 le	Gail A. Whitbred (Daughter) 6145 Fulmer Road Fr	ederick,	Md. 21703	3								
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-	23a. Part Enter the disease or complications that cause of the depth. Do not antar the mode of dying, such as cardiatock, or hear failure. 137 only one cause of each life.	FREDERI	CK, MD.	21701 Approximete								
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Within 24 hours after daar. To the Funeral Director: complately filled in by the	(Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurrence one)	curred at tha tima, c	ate and place, and d	ua to ina cause(s)								
woo	29b. Signature and title of certifier 29c. Licensa number	1	29d. Date signed (Mo	nth, Day, Year)								
	Dhaht Hugher 10511	1	1-2-200)1								
	30. Nama and address of person who completed cause of death (Item 23e) (Type, Print)											
	Robert S. Hughes, MD 700 Montclaire Ave. Freder	rick. Md	21701									
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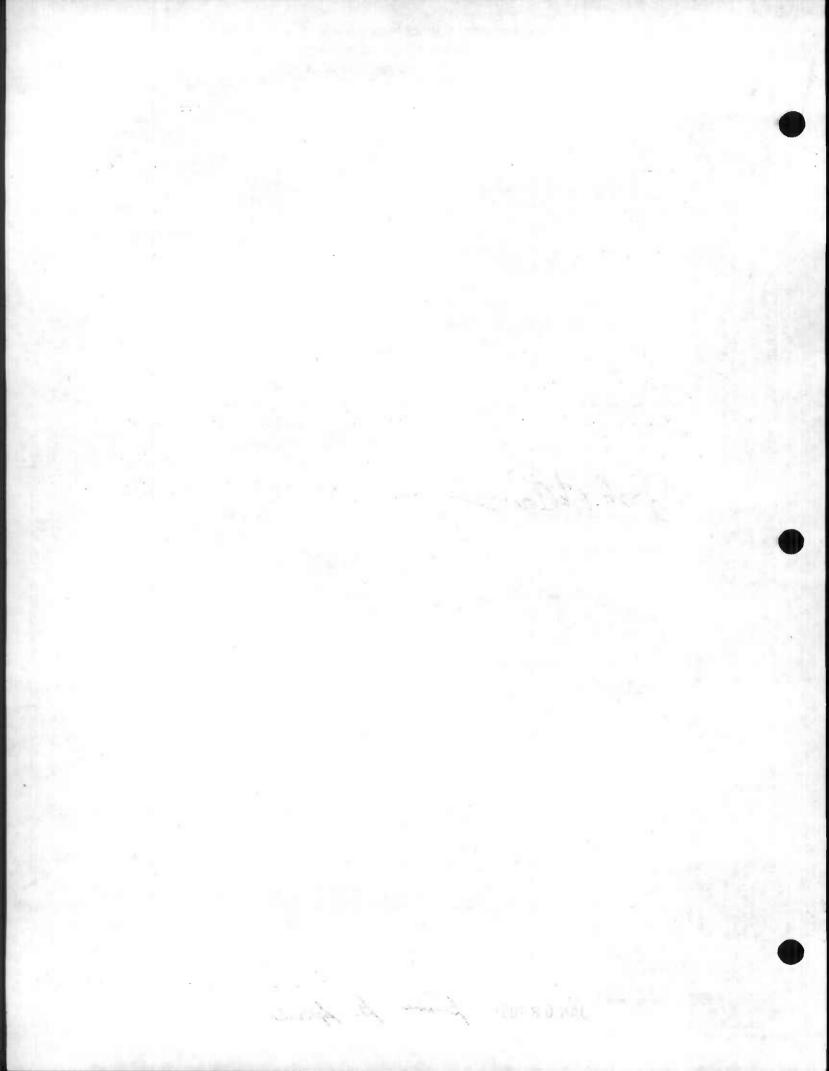
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State of Maryland / Department of Health and Mental Hygiene

HOL			oraro or many	Ce	rtificate of	Death		Reg. No.	43549		
	Physician	Decedent's Nema (First, Middle, La LIOT T.V.		mayır op			2. Data of De Month		3. Time of Death		
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Ė	Funeral Director	5. Social Security Number 6. 5		yrs. last birthday Yrs.) If Undar 1 Yaar Months Deys	If Undar 24 Hrs.		7. Y7,1958	9. Birthplace (State or Foreign Country) Maine		
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	or 28s-f a be notified Directo	10e. Sfreet end Number		Dalibba	10f. Zip Code			10g. Citizen of V	Vhat Country?		
	A STATE OF S	318 Carey Ave			2180)4		USA			
Maryland 21215-0036	un after des af, or Nerre Examinar in by Fune	11. Maritel Stetus 1 □ Never Merried 2 □ Married 3 □ Widowed 4 □ ⊅ ivorced	12. Was Decedent Evan Armed Forcas? 1 Yas 2 No If Yes, Give Yaar or Datas:	in U,S. 13.	Was Decedent of I If Yas, specify Cub 1 ☐ Yas 2 ☐ No	Hispanic Origin? (Spen, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	14. Rac Blac Specify	e - American Indian, kk, Whife, etc. White		
20	72 ho hashe disal.	15. Decedent's E (Specify only highest gri	ducation ade completed)	16a. Dece	edent's Usuel Occu	pation during most of world)	king	16b. Kind of Bu	usiness/Industry		
121	ed within 72 ho ygiene. wr then "neturn k, the Medical. Completed	Elementery/Secondary (0-12)	College (1-4or 5+)	Own		od)		Clean	i na		
d 2		17. Fether's Neme (First, Middle, Last	<u>–</u>			18. Mother's Nam	ne (First, Middle,				
lan	Mental H Mental H sife ever To Be	Walter Arr	nold			Flora	Car	rleton			
lary	and No	19e. Informent's Neme/Relationship ((Type, Print)	19b. Mail	ing Address (Stree	t end Number or Ru	ral Route Numb	er, City or Town,	State, Zip Code)		
	and	Flora C. Arnold				Dr., Jeff					
Baltimore,	permit. Pages 1 Department of H Important. If the any injury or of stice.	20e. Method of Disposition 1 Disposition 3 D	Ramoval from Stefa		emetory or other ple		Date	20c. Location -	City or Town, Stete		
Ë		4 Donetion 5 Other (Special	(y)		ry Cremato		1/4/01		oury, MD		
Ba		21. Signature of Fune all Sarvice light	Your	- F	Holloway 501 Snow	Funeral H Hill Rd.,	ome Pro	fessiona ury, MD	al Association 21804		
	Physician /Medical	23 B 11. Enter the disease, or com- back, or heart feilure. List only Immediate Ceuse (Finel						rrest,	Approximete Intervel Between Onset end Death		
	Examiner	disease or condition resulting in deeth)		to (or as a conse		noousn					
	od in in		6 DEEP (54 US	sin t	HROM B.	osy				
68760,	ificate be executed giphysician and as the burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last	c	to (or es e conse							
Box 68	2 0 0										
	by the attending teached for use letached for use. Physician/N	Part II. Other significant conditions of	confributing to death but no	ot resulting in the	underlying cause gi	ven in Pert I.	23b. Did	tobacco use co	ntribute to the cause of death?		
P.0		0155519					10	Yes 2□ No	3 Probably 4 Unknown		
Records,	been sign should be							an autopsy rmed?	24b. Were eutopsy findings available prior to completion of cause of death?		
Re	The law ate has be page 2 s						Her	Yes 2 No	1 Yes 2 No		
Vital	certificate rector, pa	25. Was case referred to medical				26. Place of Dea	th (Check only	one)			
ot v	Z 0 0	examiner? 1 Yes 2 No	Hospitel: 1 Inpatient		ent 3 DOA Ot	her: 4 Nursing H	ome 5 Resi	dence 6 Dioth	er (Specify) SCENE		
	or the	27. Manner of Deeth 1 Neturel 5 Pending	28a. Dete of tnjury (Month, Dey Ye	ar) 28b. Time (Wo		28d. Describe	how injury occur	red		
Division	Neepital or Attanding P 24 hours after death. Funeral Director: After tests filled in by the funeral etaly filled in by the funeral dical Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	OB Place of Injury	At home, farm, sipecify)		Yes 2 No	28f. Location (City or To		per or Rural Route Number,		
	Hospi 4 hours Funer taly fill	29e. Certifier 1 Certifying Processing Check only one) Certifying Processing Medical Example 1	nysician: To the best of my miner: On the bests of exa and menner steted.	y knowledge, dea mination and/or in	th occurred at the tinvestigation, in my	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and ma date and place,	anner as stated. and due to the cause(s)		
)	To the within 2 To the comple	29b. Signeture and title of certifier	me you	ull	29c. Licen O. C.	M.E		29d. Date signe JANUARY	d (Month, Day, Year) 01,2001		
	Dla	30. Nema and address of person who	B. KORE	u my		n Street	Baltim	ore, Ma	ryland 21201		
	State Registrar	31. Date filed (Month, Day, Year) JAN (8 2001 Registrer's	Ignetura De person	B. A	books					



DAY CARE PROVIDER

20b. Piaca of Disposition (Neme of cemetery, cremetory or other p

PRIVATE

20c. Location - City or Town, Stata

18. Mother's Name (First, Middle, Maiden Sumema)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 7 0 1

148 WEST ALL SAINTS ST FREDERCIK, MD.

HALLMAN

FLOSSIE

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at filed within 72 hours after Hygiene. Baltimore, Maryland 21215-0020 end Mentel Hygie Is marked other Peges 1 end 2 should be nent of Heelth end Mentel Department of Heelth el Important: If item 27 is sny injury or other trait pnce.

DERICK

with the Meryland

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

MD.

Elementery/Secondery (0-12)

17. Fether's Nema (First, Middle, Last)

19e. Informent's Neme/Reletionship (Type, Print)

RUTH ANN AMBUSH

THOMPSON

12 TH

20e. Method of Disposition

ELTON

Coilege (1-4or 5+)

Funeral

Director

Physician /Medical Examiner

Physician/Medical Examine certificate be executed the attending physicien and thed for use as the burial-tren Box The lew requires that the death Division of Vital Records, P.O. signed by Completed page 2 certificate To the Hospital or Attending Physician: within 24 hours after death. Be P

1 XBuriai 2 ☐ Cramation 3 ☐ Removel from State FAIRVIEW CEM. DEC. 1,2000 FREDERICK MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility
GARY L. ROLLINS FUNERAL HOME 21. Signeture of Funerei Servica Licansee ollins 23a. Pert1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one ceuse on each line.

RESPIRATORY FAITURE 110 WEST SOUTH ST FRED. MD. 21701 Approximete Intervel Between Onset end Deeth Immediete Ceuse (Final diseese or condition resulting in deeth) WEEKS RESPIRATORY FAILURE/ ASTHMA Due to (or es e consequance of): ASIHMIA Sequentielly list conditions, if eny, leeding to immadiate cause. Enter Underlying Ceuse (Diseese or injury that initiated avents Due to (or es e consequença of): Dua to (or as a consequance of): resulting in death) Last Pert tl. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part 1. 23b. Did tobacco use contribute to the cause of death? 1 ▼Yee 2 No 3 Probably 4 Unknown DIABETES by 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 🗆 Yas 2 X No 1 ☐ Yas 2 ☐ No 25. Wes case referred to medicat 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 X ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yas 2 ☑ No 27. Manner of Deeth 1 Defurel 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Pleca of Injury - At homa, farm, streef, factory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) and menner as stated.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, and due to the ceuse(s) end manner stated. edicai 29e. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 330 NOV. 21,2000 30. Name and address of person who completed cause of deeth (ttem 23e) (Type, Print)

State Registrar

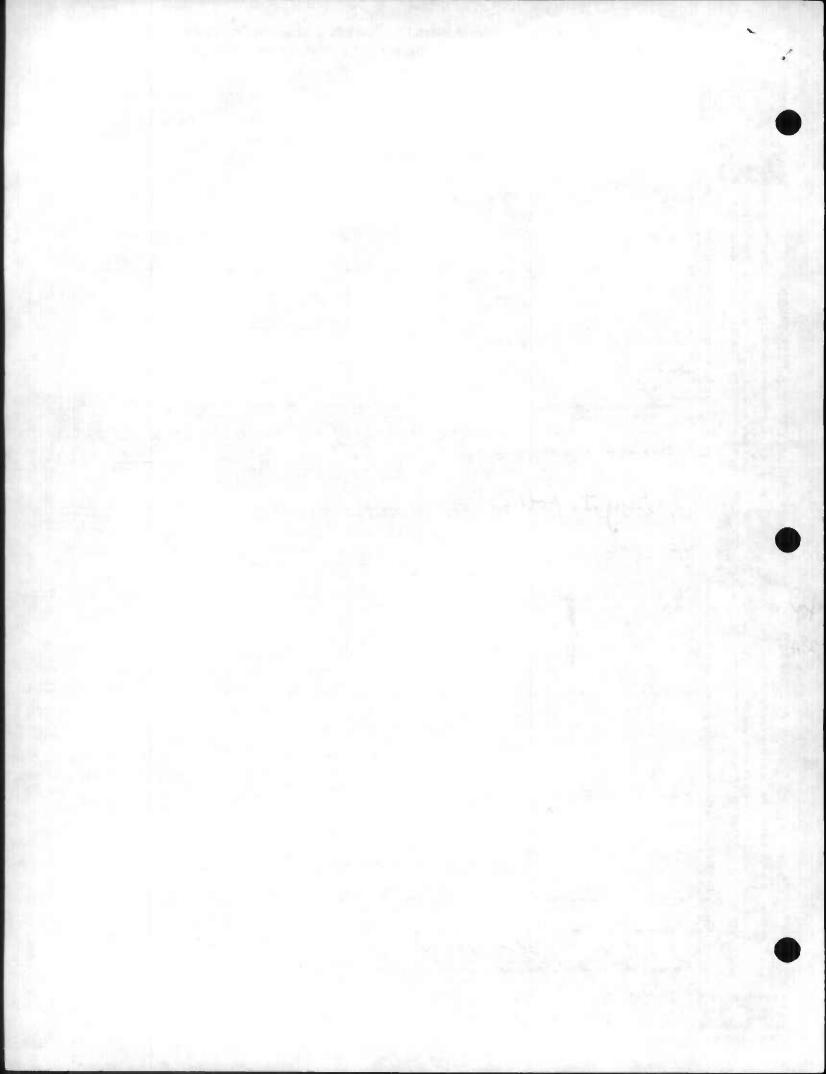
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within 24 hours aft To the Funeral Di completely filled in

FRANK LISTELLO 9901 MEDICAL CENTER DR. ROCKVILLE MD. 20850 31. Data filed (Month, Dey, Year) 32. Registrer's Signetura

DEC 0 4 2000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day **Physician** George A. Watkins December 29, 2000 2:20 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 13837 Tabonia Drive Silver Spring Montgomery If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** 1₩ 2□ F 76 Yrs 578-20-6923 Nov. 30, 1924 Washington, Director Usual Rasidance of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23e or 28e-f show the Medical Examinar must be notified at 1 ☐ Yas 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10g, Citizan of What Country? 10f. Zip Code 13837 Tabonia Drive Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Ricen, atc.) 12. Was Decedent Ever in U,S. Armed Forcas? 14. Race - Amarican Indian, Black, Whita, atc. 1 Tyas 2 No If Yas, Giva 1943—1945 Yaar or Datas: 1 ☐ Navar Married 2 ☑ Married "natural", or 1 ☐ Yas 2 ☑ No Specify: Specify: Black p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) I Hygiena. filed within Collega (1-4or 5+) Elamantary/Secondary (0-12) Operating Engineer Federal Government h and Mental Hygin is marked other 18. Mothar's Name (First, Middle, Maidan Sumama) 17. Fathar's Nama (First, Middle, Last) Be 8 permit. Pages 1 and 2 should be Department of Health and Mental Important: If them 27 is manted c any Injury or other traumatic ev-Leo A. Watkins Jessie L. Veney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Lillian Watkins / Wife 13837 Tabonia Drive, Silver Spring, Maryland 20906 Baltimore, 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Othar (Specify) Baltimore National Cem. 01/08/01 Baltimore, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signatura of Funaral Service_Licensee 11800 New Hampshire Avenue Silver Spring, Maryland Mu 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Immediate Cause (Final disease or condition rasulting in death) /Medical neumonia Examiner Dua to (or as a consequence of) Examine The law requires that the deeth certificate be executed attending physicien and for use as the buriel-transit Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disaasa or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed t by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen certificate has 1 Yas 2 TNo 1 ☐ Yes 2 LNG Physician: 25. Was case referred to medical axaminar? Be 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Assidence 8 Othar (Specify) 2 1 Yes 2 No After this spital or Attanding Physicurs after deeth.

neral Diractor: After this filled in by the funeral d 28a. Data of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work? Certification: 5 Pending invastigation 1 Yas 2 No 2 Accident 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida To the Hospital c within 24 hours at To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner on the best of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier 29d. Dete signed (Month, Day, Year) 29c. Licensa number 29b. Signature and this of certific December 30, 2000 D45062. 10+1 30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print)

Registrar

State

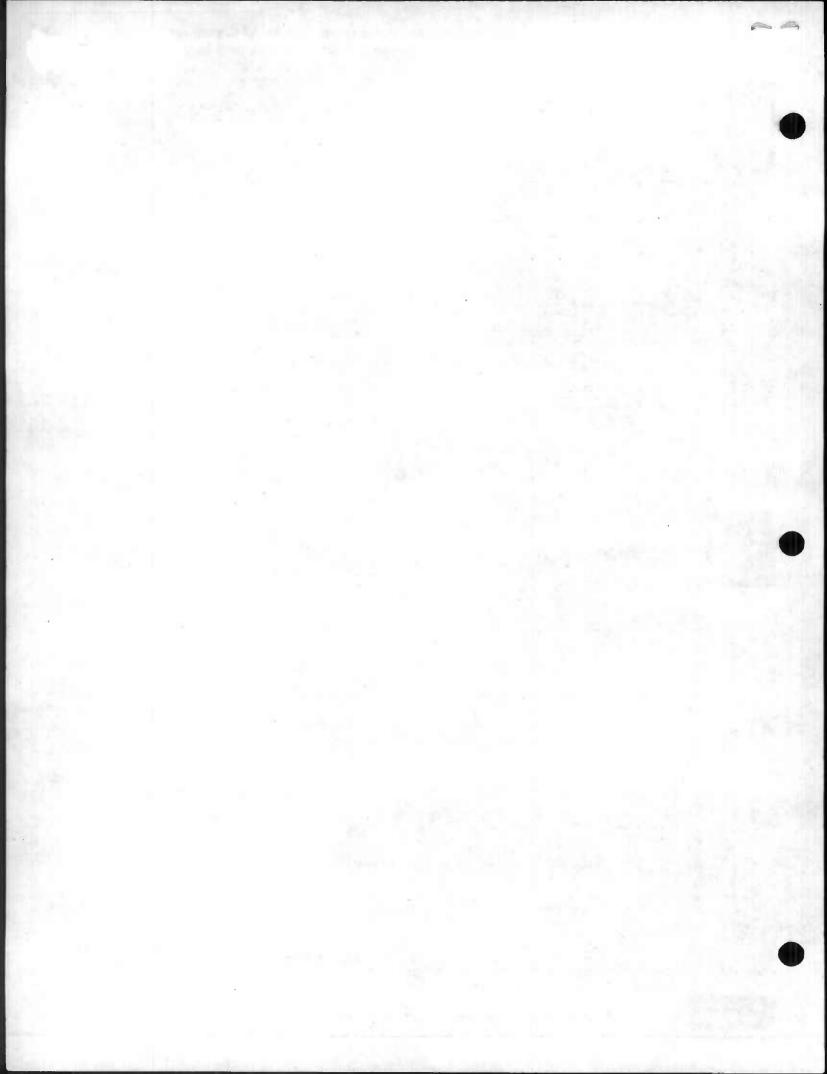
31. Date filed (Month, Day, Year)

JAN 0 8 2001

ORIGINAL

Mark D. Klaiman, M.D. 6410 Rockledge Drive, #210, Bethesda, Maryland

32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene (1) 1, 2552

					Certificate	of Death		Reg. No.	1 1	0006
		1. Decedent's Neme (First, Middle, La	ist)				2. Dete of Dec	eth Day	Year	3. Time of Deeth
	Physician /Medical	Dorothy V. Wh	eeler				Dec.		000	1855
	Examiner	4a Fecility Nama (If not institution, give	e street and number	er)		4b. City, Town, o	r Location of Deeth	4c. County	of Death	
		Carroll County G	eneral Ho	spital	10.00	Westmi	nster	Carr	011	
	Funeral	5. Social Security Number 6. S		Aga (In yrs. Ia	Montho	Yaar If Undar 24 Hr Deys Hours Mii		h v. Year)	9. Birthp	nlaca (Stata or Foraign
	Director	212-30-6624	1□M 2⊠F	95	Yrs.	Doys House Him	April 1	3 1905	Ma	aryland
	٠, ٩	Usual Rasidence of Decedant 10a. Stata 10b. County		100 City	, Town or Location				1.	0d. inside City Limits
	show	Maryland N/A		Too. Oity	Baltimore					1 W Yas 2 □ No
	vith the Marylan or 28=f show be nutfied at Director									57.000
	Direction of the second	10e. Street and Number			10f. Zip (10g. Citizan of I	What Coun	Ary?
	ath w	3702 Gibbons Av				21206				tates
	5-0020 72 hours after death with the Maryland netural; or items 23s or 28s-f show area Examiner must be notified at each of Funeral Director	11. Marital Status	12. Was Deceda Armed Forca	s?	S. 13. Was Decede If Yas, specif	nt of Hispenic Origin? (ly Cuban, Mexican, Pue	(Specify Yes or No- erto Ricen, atc.)	14. Rad Blad	e - Amaric ck, Whita,	
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	15-00: 72 hours "natural", ore Ex	3 ☐ Widowed 4 ☑ Divorced	Yaar or Data	S:				10 10 1 10		ite
	ed within 72 ho ygiena. Per than "neturi ft, tre Medical Compieted	15. Decedent's E. (Spacify only highest gre	ducetion a <i>de complatad)</i>		16a. Decedant's Usual (Giva kind of work lifa. DO NOT usa	dona during most of w	orking	16b. Kind of B	usinass/inc	Justry
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	d 212 filled within Hygiena. wher than ent, tre W	17. Father's Name (First, Middla, Last	1		Real Esta		ama (First, Middla,			
	and in the filed other sevent, sevent, Be Co									
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	Maryland 21215-0020 d2 should be filed within 72 hours aft this and Mental Hyghen "natural", or traumatic avent, tra Menical Exam To Be Completed by F	Nancy Sternad		0.30		(Street and Number or I				C009)
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-	Balt permit. Departr Importu any Inji	21. Signatura of Funaral Service Licer	nsee / d	6		Address of Facility r-Queen Fu	neral Dir	ectors.	P.A.	
0)	_ 00100	James C	(00	uge	1212 W	. Old Libe	rty Road	Winfie		
D	100000	Part Entar tha disaasa, or com shock, or haart failura. List only	plications that caus	ed the death	. Do not antar tha moda	of dying, such as cardi	ac or raspiratory er	rest,		Approximate Interval Batween
5	Physician		•						1	Onsat and Daath
2	/Medical	Immadiata Causa (Final disaasa or condition	A	cuto	, Keelo	inchang -	tealm	L		
2	Examiner	resulting in death)	a	Dua to (or	as a consaguanca of:	1	0			
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	68760, ficate be axecuted physician and is the burial-transit edical Examiner	Sequantially list conditions,	D	Dua to (or	as e consequence of):					
7	e axe urial-i	Sequantially list conditions, if any, laading to immadiata causa. Entar Undartying Causa (Disaase or injury		Der	nenha				i	
2	cords, P.O. Box 68760, requires that the death certificate be an earn signed by the attending physician hould be datached for use as the buria eted by Physician/Medical E	that initiated avants rasulting in death) Last	C		as a consequance of):				1	
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	The law requir The law requir ata has been s page 2 should Completed						10	Yas ZENo		☐Yes 2☐No
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	Division of Vital Records, tall or Attending Physician: The law requires the fare death: In prector: After this cartificate has been signed in by the funaral director, page 2 should be certification: To Be Completed by	4 Homicida determined	building,	atc. (Specify	me, farm, street, factory,)	Omco	City or To	vn, Stata)	201 OF 11010	, riodia ridinoo,
	pital pours eral filled	29a. Cartifiar 1 Certifying Ph	velelan: To the he	at of my know	viedge, death occurred a	t the time, date and ale	an and due to the	nouss(s) and m		totod
	he Hospi in 24 hound he Funer plately fill edical	(Check only 2 Medical Exar	niner: On the basis and mannar	of axaminati	on and/or invastigation, i	in my opinion, daath oc	curred at tha tima,	data and place,	and dua to	tha causa(s)
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		30. Nama and address of person who	completed ceuse of	f death (Item	23a) (Type, Print)	1.1. 1	1.16		04.5	0 21157
		DR. Raman B.	Kanevia	41	9 1 .	il colm d	ne me	stminst	NIL	2117
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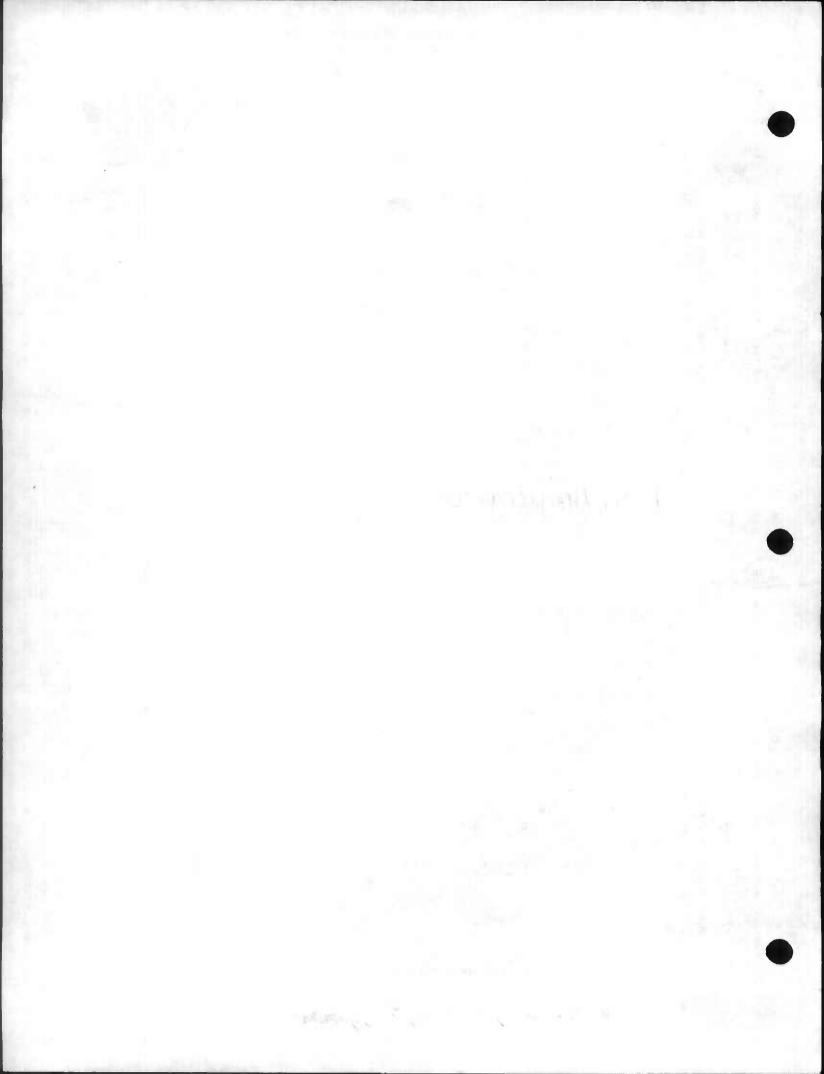
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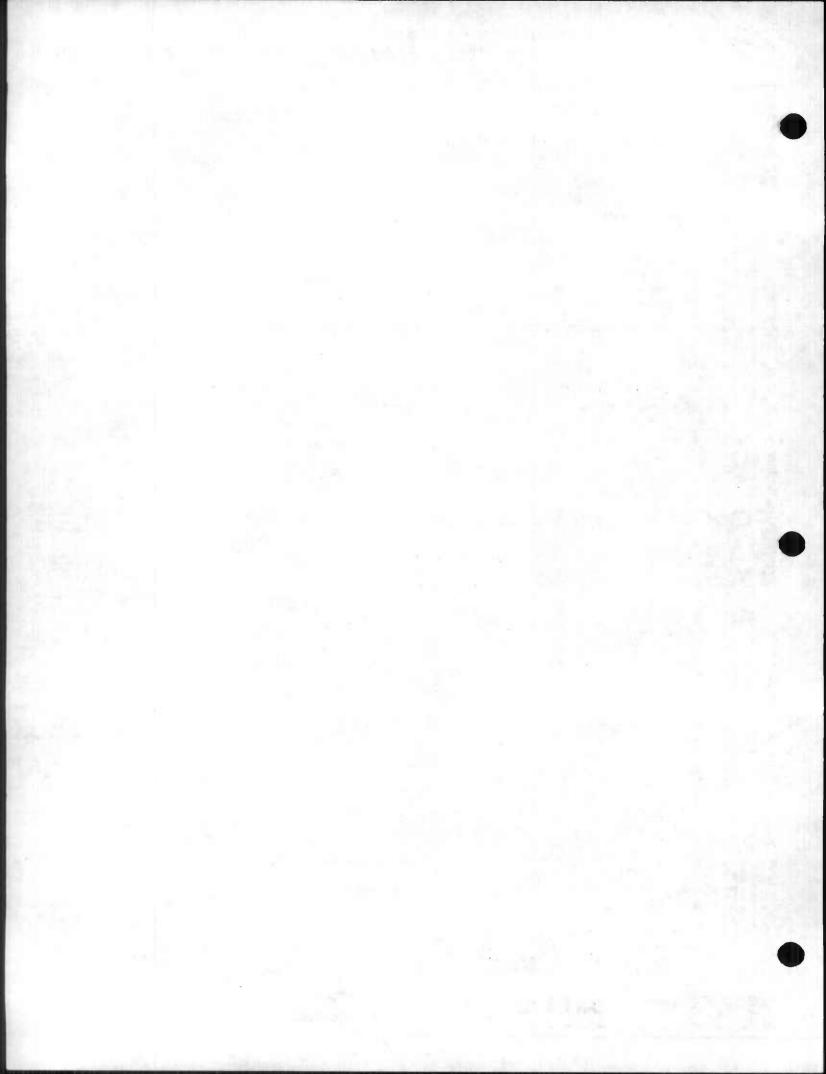
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Hospitel:				than A			
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28a. Plece of Ir building, e	njury - At homa etc. (Specify)	a, farm, straat	at, factory, office		28f. Location (City or To	Street and Numb wn, State)	per or Rural Route Number,
miner: On the basis	of examinetion	edge, deeth oo n end/or inves	occurred et the t stigetion, in my	ime, date end pla opinion, deeth oc	ca, and due to the curred et the time,	ceuse(s) end ma date end plece,	anner es steted. and due to the cause(s)
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- MO			23	2609		12/21	100
h	Hospital: 1 Inpa 28e. Date of Ir (Month, L) 28a. Plece of I building, yalcian: To the besinner: On the basis	Hospital: 1 Inpatiant 2 ER 28e. Date of Injury (Month, Day Year) 28a. Plece of Injury - At hom building, etc. (Specify)	Hospital: 1 Inpatiant 2 EP/Outpatient 28e. Date of Injury (Month, Day Year) 28b. Time of Injury 10 Injury 28a. Plece of Injury - At homa, farm, strate building, etc. (Specify) 10 Injury 11 Inpatiant 2 EP/Outpatient 12 Inpatiant 2 Injury 12 Injury 13 Injury 14 Injury 15 Injury 16 Injury 16 Injury 17 Injury 18 Inj	Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA 28c. Injury (Month, Day Year) 28b. Time of Injury M 1 28a. Plece of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 1 28a. Plece of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 1 29c. Licer	Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing 28e. Date of Injury (Month, Day Year) 28b. Time of Injury Month, Day Year) 28b. Time of Injury Month, Day Year) 28c. Injury at Work? 1 Yes 2 No 28a. Plece of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 28c. Injury at Work? 1 Yes 2 No 28a. Plece of Injury - At homa, farm, straat, factory, office by specials: To the best of my knowledge, deeth occurred et the time, date end planner: On the basis of examination end/or investigation, in my opinion, deeth oc	1	26. Place of Death (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other: 4 Nursing Home

DHMH 16 Rsv 6/95



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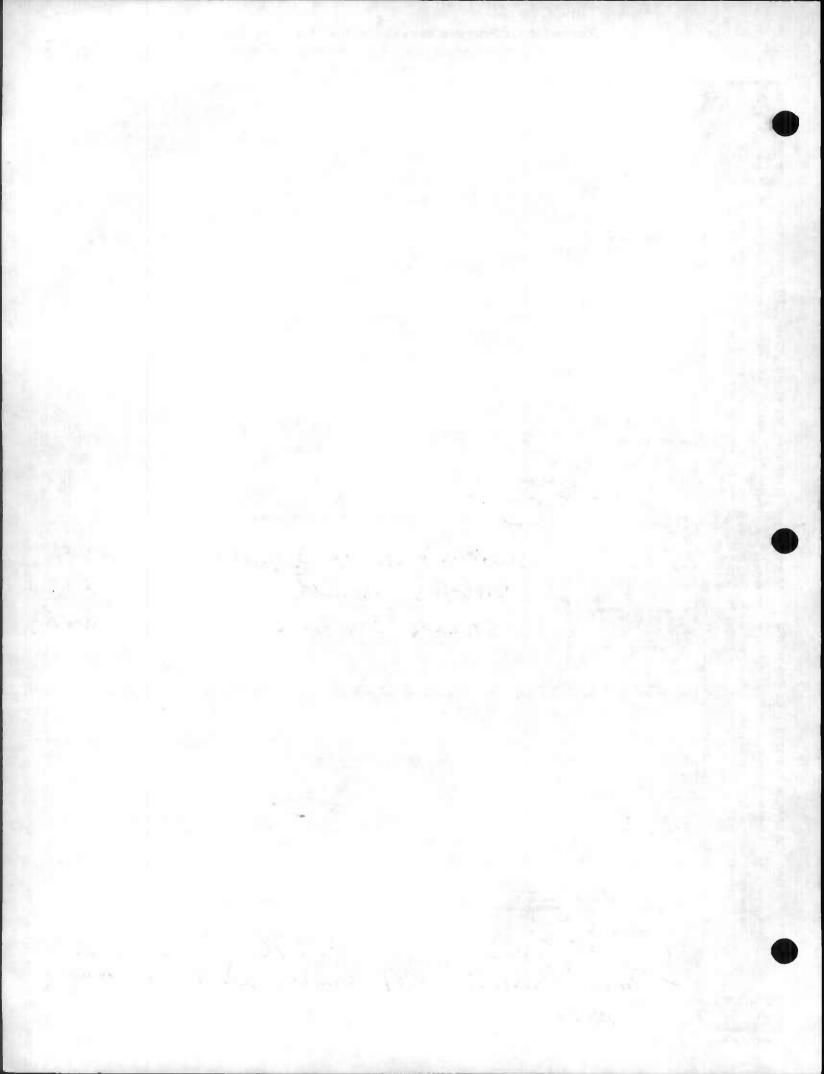
				of Maryland		rtificate					Reg. No.	70	554
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/Medica		Melvin Danie	ls, III							7	25 20	000	3:56AM
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		Maryland Gen		-					timo			,	- 11/1
Funeral		5. Social Security Number	6. Sex 1⊠M 2□ F	7. Age (In yrs. I	ast birthday) Yrs.	Months	Days	If Under Hours	Min.	8. Date of Bi	rth ay, Year)	9. Birth	place (State or Foreign ntry)
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2 1		10a. Stete 10b. County		10c. City	, Town or L	ocation							10d. Inside City Limits
fah	50	MD		Pa	ltimon								1 □ Yes 2 □ No
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o and	F	1 Never Merried 2 Merrie	Armed F	orces? 2⊠No		If Yes, specif	y Cube	n, Mexica	n, Puerto	Rican, etc.)	Ble	ck, White,	
Line at	p	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Yeer or I	ive		1 Yes 2	No No	Specify:			Specify	y: Bla	ick
72 hours restursif,	pet	15. Decedent'	s Education		16a. Dece	dent's Usual	Occupa	ation	t of work	ring	16b. Kind of B	usiness/In	dustry
21215-0036 d within 72 hours at giene. r than "natural", or the Medical Exam.	eld.	(Specify only highest Elementery/Secondery (0-12)		(1-4or 5+)	life.	DO NOT use	retired)	SE OF WORK	uig			
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altimore, mit. Pages 1 a partment of Hea portant: if Nem y injury or othe		20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation	3 🗆 Removel from	C	emetery, cre	osition (Neme metory or oth	er plec	e)		Dete	20c. Location		own, Stete
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00180		Terry C. Gentr								imore Md			
Physician /Medical Examiner	16	23a. Pert1. Enter the disease, or shock, or heert failure. List of the control of	a. Car	rdiac ar	rest res e conse	quence of):							Interval Between Onset end Deeth
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ate be hysicia the bur	edical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. Per	ripartum	feta. as a conse	dist	ress	3					
death certific attending p	by Physician/M	Pert II. Other significant condition	d	death but not resu	ulting in the u	undertying car	use give	en in Pert	1.	23b. Did	tobacco use co	ontributs	to the cause of death
res that the de signed by the s	y Phy									10	Yss 2⊠No	3□ Pro	obably 4 🗆 Unknow
HECOLOS, le law requires ti) hes been signe ge 2 should be	Completed b									24e. Wei	s en autopsy ormed?	an Ci	Vere eutopsy findings veilable prior to ompletion of cause f death?
The law	COL									PO	Yes 2□No	0	Yes 2 No
ysician: The	Be	25. Wes case referred to medical examiner?						26. Plac	e of Dee	th (Check only	one)		
- K O	To	1⊠Yes 2□ No	Hospitel:	Inpatient 2	ER/Outpatie			4 L N	ursing H	ome 5 🗆 Res	idence 6 Ott	her (Spec	ity)
Low Attending Ph after deeth. Director: After th d in by the funeral	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n	etion of he	nth, Day Year)	28b. Time of Injury	М		y et k? Yes 2□] No		how injury occur		
UNISIC tal or Attend is after deeth al Director:	Certif	4 Homicide determine	ned 288. Mec	a of Injury - At ho ding, etc. (Specify	me, ferm, si	reet, fectory,	office				(Street and Num. own, State)	ber or Rui	ral Route Number,
To the Hospital or within 24 hours af To the Funeral Di completely filled it	Medical	29a. Cartifier 1 ☐ Certifying (Check only 2 ☑ Medical E	Physician: To the xaminer: On the b and mer	e best of my know basis of exeminet nner steted.	wledge, deel ion and/or in	th occurred envestigetion, i	t the tin	ne, dete al pinlon, de	nd piece, ath occur	and due to the red at the time	cause(s) end m , date and placa,	anner es and due	stated. to the cause(s)
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		1 , 602	Fells	N				OCM	Œ		Re-issu	ed 1	-19-01
	1	30. Name and address of person v	·						411				
		J.Laron Locke,	M.D.	111 Pe	enn St	., Bal	tim	ore,	MD	21201			



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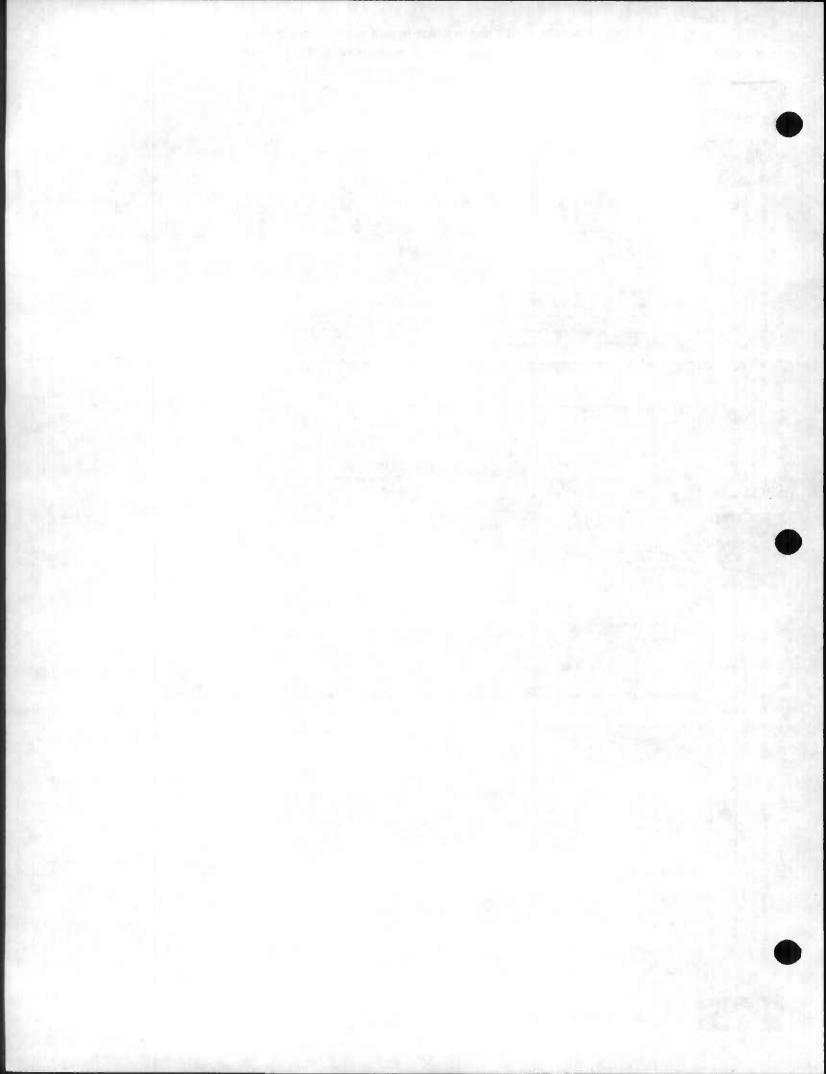
State of Maryland / Department of Health and Mental Hygiene 0 4 3 5 5 5

					Cel	rtificate	e or i	Death		R	eg. No.		
Physician /Medical	Decedent's Name (First, M Cerald L. Wood	liddle, Last) dl.and				di.				2. Date of Dea Month	Dey	Year 2000	3. Time of Death 11:30 am
Examiner	4e Facility Neme (If not instituted Heritage Harbour				nter			4b. City, To		ocation of Deeth	4c. C	Anne And	1
uneral irector	5. Social Security Number 026-01-0357		M 2□F	7. Age (In yrs. 94	last birthday) Yrs.	If Under Months	1 Year Deys	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day May 31,			nplaca (State or Foreign untry) Canada
ž u	Usuat Residence of Decedent 10a. Stete 10b. Cou			10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits
Ner must be notified at tuneral Director	MD	Anne .	Arundel					is Mar	yland				1 ☐ Yes 2 ☑
23s or 3 ant be n	2700 South Have	en Road				10f. Zip		401			og. Citize	en of What Co- United	States
by F	11. Merital Status 1 Never Merried 2 Never Me	Married	2. Wes Dece Armed For 1 Yes It Yes, Give Year or Da	2∕∑No	10 10	Wes Deced If Yes, spec 1 ☐ Yes 2	ify Cube	ispanic Orlean, Mexican Specify:	gin? (Sp , Puerto	ecify Yes or No- Rican, etc.)		4. Raca - Ame Black, White Specify:	
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atic event	17. Father's Name (First, Mide Albert L. Wood	. ,						18. Mothe		abeth H.			
27 is me r trauma	19a. Intermant's Name/Relati Barry Woodland					ng Address 4 Autur				al Route Numbel			
nt. If item ry or othe	20a. Method of Disposition 1 Buriel 2 Cremeti 4 Donation 5 Othe		emoval trom S	tata	Place of Dispo cometery, cres witan Li	metory or o	ther plea		nuary	Date 4, 2001		ation - City or Peabody	
Importa any inju	21. Signature of Funeral Serv	vice License	• Wictor	P. Doda	O	harles	L. S	tevens	Fune	ral Home, Baltimore	Inc.	1and 21	230
	23e. Pert1. Enter the disease shock, or heart taiture.	e, or complic List only on	cetions that ca e cause on ea	used the deet ach line.								1810 21	Approximate Interval Between Onset and Death
rsician ledical aminer	Immediate Cause (Final disease or condition resulting in death)	a.	Co	7400a	1)/0	asse	14	2.	s-e	all			y,s
in in				Due to (0	or as a consec	quence ot):	. The	it.					X/S.
Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	6.		5112.	or es a consecue	DV	Suc	Ver				1	Monsky
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by the tached	Part II. Other significant cond	ditions cont	tributing to de	ath but not res	ulting in the u	inderlying ca	ause giv	en in Part I		23b. Did to		1	to the cause of death obably 4 Unknow
should be										24a. Wes a perfor	n autops med?	'	Were autopsy tindings evailable prior to completion of cause of death?
page 2										1□ Y	es 2	No	1 ☐ Yes 2 ☐ No
i certificate director, par o Be Co	25. Was case reterred to med examiner?	-	ospital:				Oth	er _ /		h (Check only or			
# F	1 Yes 2 No 27. Manner of Death 1 Matural 5 Per	nding estigation		npatient 2 t Injury n, Day Year)	28b. Time o Injury		8c. Injur Wor	4 NU		rne 5 ☐ Resid 28d. Describe h			erfy)
주 후		ostigation		of Injury - At h	ome, tarm, str					28t. Location (S City or Tow		Number or Ru	irel Route Number,
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ca the	3 Suicide 6 Codet 4 Homicide	fying Physi	buildin	eg, etc. (Specif	wledge, deetl	h occurred	et the tin	ne, dete en pinlon, dee	d plece,	end due to the c	euse(s) e	end menner es place, and due	stated.
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To the Funeral Director: All completely filled in by the fur Medical Certification	3 Suicide 6 Codet 4 Homicide 29a. Certifier Certifier (Check only one) 2 Medione	fying Physical Examinatifier	ician: To the base and mann	g, etc. (Specification) best of my kno sis of examina er steted.	wiedge, deetl tion and/or in	h occurred evestigation,	in my o	pinlon, dee	d plece, th occur	end due to the cred at the time, d	euse(s) e ate and p	ptace, and due signed (Monti	to the cause(s)



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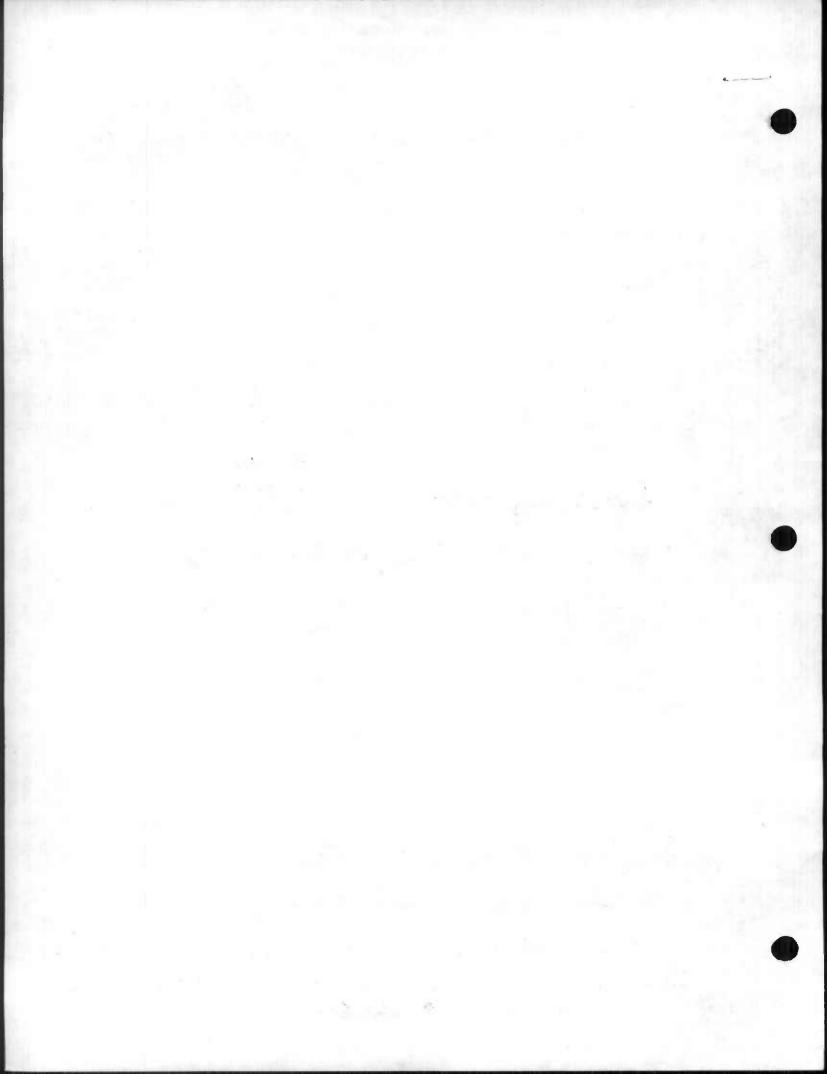
oa, 4/	28a,b,c,d,e	,f per me	G791 1/3	1/01yf	Ce	ertifica	ate of	Death	1		Reg. No.		
sician	1. Decedent's Name Monay Si			Wilson	1					2. Date of D Month Decem	Day	Yaer 3, 2000	3. Tima of Death 7:53 P.M
edical miner	4e Facility Name (/				==10:			4b. City, To	own, or L	ocation of Dea	th 4c. Co	ounty of Death	h
ral	Peninsu. 5. Social Security N	la Regio	nal Med		enter s. lest birthdey	al If Und	ler 1 Year		Lisbu			Lcomico	
	216-55-8		1□M % □F	7. Aga (M y).	Yrs.	Month		Hours	Min.	8. Dete of 8 (Month, D			hplace (State or Foreign untry) 1 Land
	Usual Residence of	Decedent			L		1			jourc o		Z ILICAL Y	
	10a. State Maryland	10b. County Wicon	nico	100.0	City, Town or L Sali	sbur	7.7						10d. Inside City Limits 1 Yes 2 No
	10e. Street and Nur		1100		5011		Zip Code				10g. Citize	n of What Co	4.4
	432 Ea	st Colle	ege Aven	iue			21804	-			USA		
	11. Merital Status 1 Never Marri 3 Widowed	ied 2 Married	Amed	2 No Give	U,S. 13.		cedent of Hoecify Cuba	lispanic Or an, Mexica Specify		ecity Yes or N Rican, etc.)		Bleck, White Bleckity:	
	(Spec	15. Decedent's city only highest g	Education trade completed	1)	(Giv	a kind of v	sual Occup work done	during mo:	st of work	ing	16b. Kind	of Business/I	Industry
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1	17. Father's Nema	(First, Middle, La	st)		Non	IC		18. Moth	er's Nam	e (First, Middle		one one)	
	Donta M	ills					-17		Tar	nya Wil	son		
	19e. Informant's Na									el Route Num			
	Tanya Wi		her	l-a				.ege A	Ave.,		_		and 21804
		☐ Cremation 3		n State	Place of Disp cemetery, cra	ametory o	r other ple		i	Date		tion - City or	
	4 ☐ Donation 21. Signature of Fu	5 Other (Spec	•	Sc	ringhill			ardens		2-23-00	Hebran	, Maryla	and
		M. Handy,			5	Stewa	art Fi	unera	1 Ha				
	23a. Part1. Entar ti shock, or hea	he disease, or co	mplications that	t ceused the de	ath. Do not er	821 The m	West ode of dyir	Road,	, Sa] s cardiac	or raspiratory	Mary errest,	rland 2	21801 Approximata Interval Between
Physician/Medical Examiner	Immediate Cause (disease or condition resulting in deeth) Sequentially list conif any, leading to imceuse. Enter Under Cause (Disease or that initiated avents resulting in death) I	nditions, nmediate orlying Injury	b	Due to	Or es a conse	equence o	of): of):						
			d										
	Pert ii. Other signif	icant conditions	contributing to	death but not re	esulting in tha	underlying	g cause giv	ven in Part	l.			-	to the cause of death
										10	Yes 213	MO 3∏PI	robably 4 ☐ Unknow
										24a. Wa per	s an autopsy formed?	8	Were autopsy findings available prior to completion of cause of death?
										18	Yes 2	No 1	1 X Yes 2 □ No
	25. Wes case refer examiner?	red to medicet					1-		e of Deel	th (Check only	one)		
	1 X Yes 2 ☐ 27. Manner of Death		28a Dat	e of Inium	ER/Outpatie		DOA		lursing Ho	ome 5□Res			
	1 Naturel	5 Pending investiget	found	12/18/0	1 Injury		28c. Injui Wor	rk? Yes 21 <u>K</u>] No	assault	ed	occured 20	bject was
	3 ☐ Suicide 4 🖾 Homicide	6 Could not determine	buil	ce of Injury - At ding, etc. (Spec	home, farm, s	treet, fact	ory, office			28f Location #2 City or To Salis	(Street and own, State)	Number or Au /16 S. D Maryland	viral Route Number, Division St.,
	29a. Certifier (Check only	1☐ Certifying F 2☑ Medicai Ex	eminer: On the										
	one)		and the			2	29c. Licens	se number			29d. Date	signed (Monti	h, Day, Year)
	29b. Signatura and	title of certifier											
		title of certifier	2 Ch	tens				O.C.N	1.E.		Decemb	er 19,	2000
Medical Certification:	29b. Signatura and	uni		UFNO use of death (Ite						ltimore			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 4 3 5 5 7 State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Physician Month December 31 0006 2000 D. Blackmon Michele /Medical 4c. County of Death 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Southern Manyland Hospital Clin ton Prince George's Center W Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 13, 15 9. Birthplace (State or Foreign Country)
Phila., Pa. 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** Days Months 1□M 2CXF Director 45 198-46-9136 Usual Residence of Decede the Marylend 10a, Stata 10b. County e filed within 72 hours after deeth with the Marylan bi Hyglane. other than "naturel", or frems 23s or 28s-f ahow vent, the Medical Experience the notified in 10c. City. Town or Location 10d. fnside City Limits Forestville Prince George's 1 Yes 2 No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20747 2110 Brooks DR. #217 Funeral 14. Race - Amarican Indian Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specity: Black 21215-0020 1 Yes 2 No Specify: g 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Beautician 12th Baltlmore, Maryland 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: if Item 27 is marked oth any Injury or other treumatic evant pages. 18. Mother's Nama (First, Middle, Maiden Surnama) Be Lillian Rayford Henry L. Blackmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Shontel Blackmon / Daughter 3700 9th St. S.E. Washington, D.C. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cem. 1/5/01 | Adelphi, Md. 21. Signature of Funeral Service Ligeru 22. Nama and Address of Facility Alexander S. Pope Funeral Homes 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart lailure. List only one cause on each line. 5538 Marlboro Pike/Forestville, Md. 20747 Approximata Interval Between Onset and Death **Physician** with Cardiomyopas Immediata Cause (Final disease or condition resulting in death) /Medical . Sstenie Lupus Examiner Due to (or as a consequence of) Examiner icien and burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physicien s the burial Box 68760. Physician/Medical Due to (or as a consequence of): 8 080 signed by the at d be detached fo P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, p 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 1 Yes 2 No 1 ☐ Yas 2 ☐ No of Vital or Attending Physicien: director. Be 25. Was case refarred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 12 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1- Naturel after deeth. 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 ☐ Homicide Hospital 24 hours Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) 2 Middical Examiner: On the basis of examiner and manner stated. To the Within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) I Av havy 00 2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Cheverly, Drive 32. Registrar's Signature 31. Data filed (Month, Day, Year) State JAN 0 8 2001 Registrar



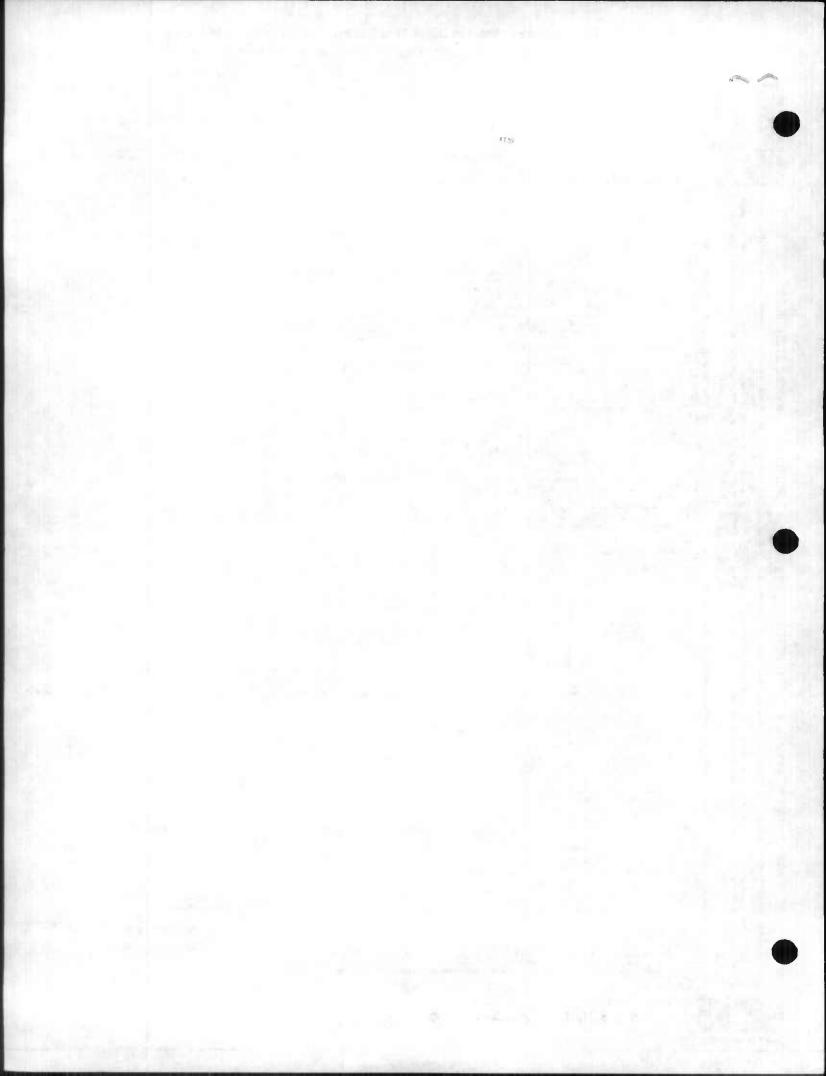
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible 4 3 5 5 8 State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Month Year **Physician** Bo wie loanna 2000 5:00 PM 20 December /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 24 Hrs. 8. Date of Birth Hours Min. May 18, 1922 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yeer **Funeral** Days Months 1□M 20 F 78 Director Virginia 577-20-8321 with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 U.S.A. 21401 901 Beacon Way or Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status Was Decedent Ever in U.S. Armed Forces? 14. Raca - American Indian, Bieck, White, etc. filed within 72 hours after 1 Never Married 2 Merried 1 Yes, Give Yeer or Dates: 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: white by 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assisant Washington Gas Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 8 permit. Pages 1 and 2 should be to Oppartment of Health and Mental important: if them 27 is marked of any injury or other treatmetic eve. Sarah M. Rosenberger Guy W. Belton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 901 Beacon Way; Annapolis, MD 21401 Richard M. Bowie / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Buriai 2 Cremation 3 Removal from State Lincoln Cemetery January 5, 2001 Brentwood, MD 4 Donation 5 Other (Specify 21 Signeture of Funerel Service Line 22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 ellow Part Enter the college, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or hand facilities. List only are cause on each line. Approximete Interval Between Onset and Deeth **Physician** mets /Medical Immediate Cause (Final a Congestive Henry Failure disease or condition resulting in deeth) Examiner Due to (or as e consequence of): Examiner no non Fuilure The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequenca of): the burial-tran Box 68760. Multiple Myelona Months physician Physician/Medical Due to (or as a consequenca of): 88 lor use Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. be detached 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 Yes 2 No 1 Yes 2 No certificate tal or Attending Physician: The safer death.

st Director: After this certificate led in by the luneral director, pa Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1. Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the ceuse(s) and manner stated. 29a, Certifier completely (Check only one) 29b. Signeture and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 3 December 30, 2000 D0051301 15 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Kongolis, MRyla 2149 Kenn & Knort MD 900 Besty 4te Road Suite 300 31. Date filed (Month, Day, Year) _32. Registrar's Signature State JAN 0 9 2001 Registrar

DHMH 16 Rev 6/95



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Amended Ite	m#23a perPHYG791 1/29/01	EW	Certifica	te of	Death		Reg. No.		
Physician	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of Death
/Medical	A - 100 A1 414 A1 A1 A1 A1				4b. City, Town, or Lo		28 2000 h 4c. County		2318
Funeral Director	ANNE ARUNDEL ME 5. Social Security Number 6. Ser	DICAL CENTER		er 1 Year	ANNAPOL, T 1 Under 24 Hrs. Hours Min.	S. Date of Bir (Month, Da	ANNE	ARUN 9. Birthpl Count	ace (State or Foreign
2 .	Usual Residence of Decedent 10a. Stete 10b. County	10c City	Town or Location					10	Od. Inside City Limits
with the Marylar a or 28a-f show be notified at Director		100. Ony,	TOWN OF ECCATION					"	1 Yes 2 No
or 28s-f.	MARYLAND ANNE AR	UNDEL ANNA	POLIS 10f. 2	ip Code			10g. Citizen of V	Vhat Coun	trv?
Sa or		OTDOLE		1401			USA		
her death here county lines must	418 A. CAPTAINS 11. Marital Status	12. Wes Decedent Ever in U.S.	. 13. Was Dec	edent of h	Hispanic Origin? (Sp	ecity Yes or No	- 14. Race	- America	
alf, or the Examine	₩idowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:		2 No	an, Mexicen, Puerto Specify:	Hicen, etc.)	Specify	k, White, 6	
72 ho matur dical	15. Decedent's Edu (Specify only highest grade		16a. Decedent's Us	ual Occup	pation during most of work	ina	16b. Kind of Bu		
d within 72 hours at glans, "natural", or the Medical Exam Commissed by	Elementary/Secondery (0-12)	College (1-4or 5+)			during most of work d)		MARYLAN		
		0	CLERICA	L AS	18. Mother's Nemo	. /First Alidella	TAX DIV		JN
nd be sental H server a server		L T ARD			VIRGINIA			6)	
Day of Marie	19a, Informant's Name/Reletionship (Ty		19b. Meiling Addre	ss (Street	and Number or Run	al Route Numb	er, City or Town,	State, Zip	Code) 21061
nd 2 should be file with and Mental Hy 27 is manked other of traumatic event	DOMINIQUE CULLE			CAYE	R DR. AT	PT. 71	3 GLEN	BURN	VIE, MD.
of Herri	20a. Method of Disposition	COL	ice of Disposition (A	eme of	cel	Date	20c. Location -	City or To	wn, State
Pages 1 nent of He mt: If Iben rry or oth	1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	L CREST			/4/01	ANNAPOI	JIS,	MD.
Departs Departs Imports any inh	21. Signature of Funeral Service License	m00483	22. Name WM .	and Addre	ess of Fecility SE & SONS	MORT	UARY, I	.A.	
	23a Part1. Enter the disease or cornel	cations that caused the death	821	WEST	ST. AND	VAPOLI	S, MD.	2140	O 1 Approximate
Physician	23a. Part1. Enter the disease, or complished, or heart failure. List only or	e cause on each line.	1	n di dyn	ng, suon as cardiae	/			Interval Between Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	Myoca	Volal		Infavi	dio	2	1	mmelint
executed in and interest		SARCODOSIS	as a consequence of		3			1	
icate be executed physician and s the burial-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury	SPULMONARY	FIBROSIS):)				
	resulting in death) Lest		es é consequence o):	filor	05/	5		
death certification of the second of the sec	Part II. Other eignificant conditions con	tributing to death but not result	ling in the underlying	Ceuse di	ven in Part I	23b Did	tobacco use cor	ntribute to	the cause of death?
that the ned by the detache	September 2 of the september 2 o		ang ar are underlying	, souse gi	OTHER OILS		Yee 2□ No	3 Prot	
redu shoul						24a. Was	an autopsy ormed?	ava	ore autopsy findings allable prior to appletion of cause death?
The lew ate has page 2						1 🗆	Yes 20 No	10	Yes ZIZINO
delan: The certificate rector, pag	25. Was cese referred to medicet				26. Plece of Deat				
Physician: this certific ral director,	examiner?	ospital: 1 ☐ Inpatient 2 🂢 E	R/Outpatient 3 1	OOA Oth	her		idence 6 Oth	er (Specify	1)
ng Phy fter this uneral d		28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo		28d. Describe	how injury occurr	ed	
or Attending after death. Director: After J in by the fune ertification	2 Accident investigation 3 Suicide 6 Could not be		М	1	Yes 2□No				
tal or Attanding P rs after death. al Director: After t led in by the funer Certification:	4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, fact	ory, office			Street and Numb wn, State)	er or Rura	I Houte Number,
To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director, Medical Certification: To Be 6	29a. Certifier Certifying Phys	Iclen: To the best of my knowler: On the basis of examination and menner stalled.	ledge, death occurre on and/or investigation	d at the ti	me, dete and piace, opinion, deeth occurr	and due to the red at the time,	cause(s) end me dete and place,	nner es st	ated. the cause(s)
To the	29b. Signature and title of perpitier		2	9c. Ligan:	se number		29d. Date signed	Month,	Day, Year)
	1 X Sold	and		1)	452	43	121	29	100
	30. Name and address of person who co	mpleted cause of death (Item 2	23a) (Type Print)	4	-1)	Aprilap	04/0	Mit
	H-0, (5014	Stein 1	n1)	2	05 /	1 de	rely	14	VR 2/80
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire 4	6-	1	/	/		

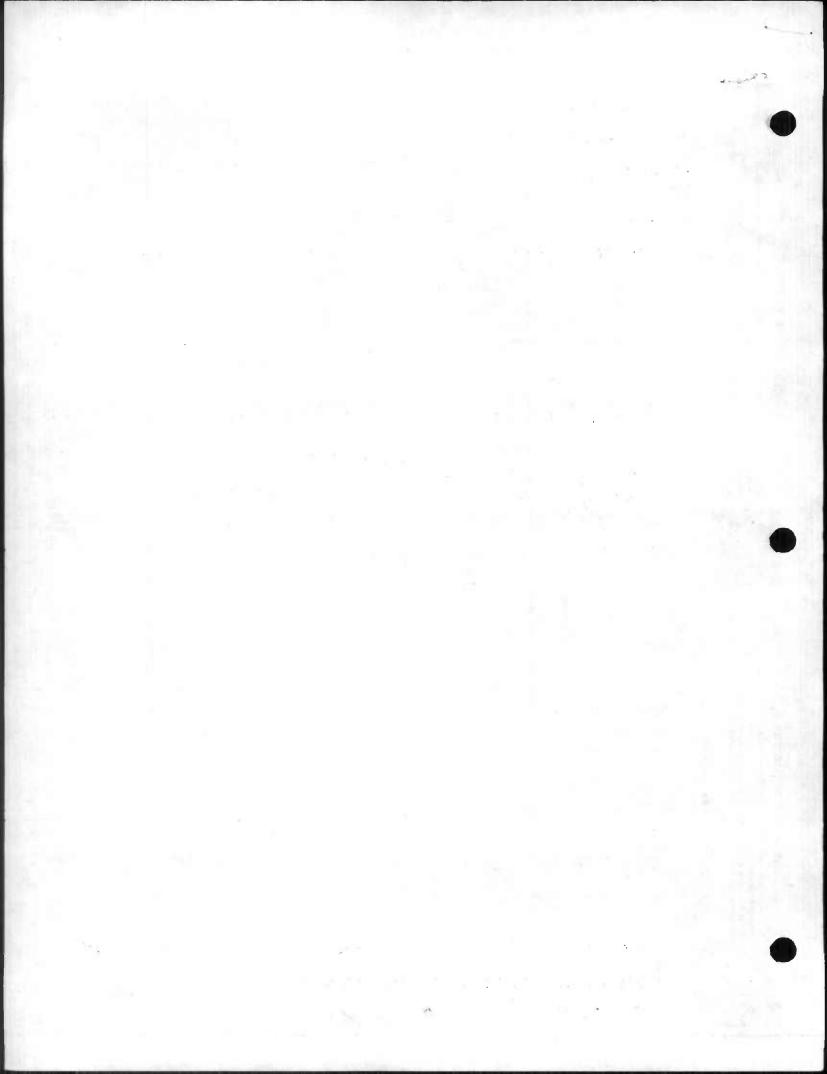
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State of Maryland	/ Department of	f Health and	Mental	Hygiene	U
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Am	end	#8.Per FH PGC 1- 1. Decedent's Name (First, Middle, La		-	Cer	tificate of	Death	2. Date of De	Reg. No.		3. Time of Deeth
Physic		MICHAEL EUGENE F						Month DECEMBE	R 30 2	Year 2000	8:35 am
/Medi Exami		4e Facility Name (If not institution, give		r)			4b. City, Town, o	r Location of Deat	-		
L-Adiiii	161	7106 WILLOW HILL	DRIVE				CAPITOL	HEIGHTS	PRINCE	GEORG	GES
Funeral Director		5. Social Security Number 6. S 578-68-0433	70 · · · □ ·	ge (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days			195	9. Birthpla OWASH	ce (State or Foreign INGTON, DC
y .		Usual Rasidence of Decedent 10a. State 10b. County		100 City T	or l so	ation			28,	Lan	4 1-14-03-11-1-
the Maryland r 28a-f show notified at	*		ODORO	10c. City, To						100	Inside City Limits T Yes 2 □ No
28a-1	Directo	MARYLAND PRINCE GI	LUKGES	CAPITO	JL nr	10f. Zip Code			10g. Citizen of V	What Countr	41.2
23s or	100	7106 WILLOW HILL	DRIVE				743		U.S.		
Barras Inst.m	by Funeral	11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 M Yes 2 If If Yes, Give Yeer or Detes	[?] 1976	13. W	/as Decedent of I Yes, specify Cut ☐ Yes 2 No		(Specify Yes or No erto Rican, etc.)	Specify	e - American ck, White, et BL	
72 TZ	pete	15. Decedent's E	ducation ade completed)	11	6a. Deced	ent's Usual Occu	pation during most of w	orkina	16b. Kind of Bu	usiness/Indu	stry
Within the same	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. D	O NOT use retire	id)		U.S. P	OSTAL	SERVICE
42 ahould be fled within 72 hours at h and Mental Hygiero. 7 is marked other than "natural", or treumetic event, the Medical Exam	Be	17. Father's Name (First, Middle, Last, EUGENE FLEMISTEI					18. Mother's N	ama (First, Middle	, Maiden Suman	10)	
thould Man	10	19a. Informant's Name/Ralationship (1,	9h Mailin	Address /Stree		Rural Route Numb	er City or Town	State 7in C	Cordel
od 2 and 2 a		SHIRLEY A. FLEMIS						VE CAPITO			
vernit. Pages 1 ar Nepartment of Hear Important: if Item in Iny Injury or other NDSA.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐		ceme	etary, crem	ition (Name of atory or other pla OLN CEMI		Data 1-5-01	20c. Location -		
Party P		4 Donation 5 Other (Specifical Service Licer				Name and Addr		1-5-01	DREMINO	OD, FI	MILAMD
Dep Impa Impa Impa Impa		1 (x929a	Mol	015				NERAL HONG ROAD	ME BRENTWOO	D, MD	20722
Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death)		IN DEPE		DIABET	ES			1	Onset end Deeth
outed of rensit	Examiner	Sequentially list conditions	b	Due to (or as	e consequ	ence of):					
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thet the ed by th detache	/ Physician/M	Part II. Other algnificant conditions of DIABETIC RETINO		but not resultin	g in tha un	derlying cause gi	ven in Part I.		Yes 2X No		he cause of death?
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To the Hospital or Attanding is within 24 hours after death. To the Funers Director After completely filled in by the funer	edical C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Example 1	ysician: To the best niner: On the basis of and manner s	of examination	ige, death and/or inve	occurred at the ti estigation, in my	ima, data and pla opinion, death oc	ce, and due to the curred at tha time,	cause(s) and ma data and place,	annar as sta and dua to t	ted. he cause(s)
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-)	> SE Au	Jerson	V		D0015	558		JANUARY	3, 20	01
(m)		30. Name end eddress of person who									
10/		S C ARYANGAT, MD				RANIER	, MD 207	12			
Sta	te	31. Date filed (Month, Day, Year)	\$2. Regist	rer's Signature		B 1.2-					

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #16b per fh G791 012901 SS 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima of Deeth Month Yeer 2/12/16/24 Segility Name (If not institution, give street and number) DORDON 2000 4b. City, Town, or Location of Death 4c. County of Death Gen. truvdel Junder 1 Year po/13 If Under 24 Hrs. (8. Date of Birth (Month, Dey, 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 10 M 2 F Months Days Hours Min. Yrs. 573-38-1042 19, 1932 Missouri Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 1XX es 2□No San Bernardino California Redlands 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1208 West Palm Street 92373 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, 11. Merital Status 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married XX Married 1 Yes 2√ No Specify: Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Medical Vocational Nurse yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First Middle Last) Nicholas Zaharia Barbara Schoffer 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) James E. Gordon/ Husband 1208 West Palm St. Redlands, CA 92373 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5 Other (Specify) Hillside Cemetery 12-24-00 Redlands, CA 22. Name end Address of Facility George P. Kalas Funeral Home of Funeral Service Licensee 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Heart Disease Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as e consequence of): Due to (or es e consequence of) Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably Wunknown 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy 2 0 No 1 Yes 1 Yes 2 No 25. Was case referred to medical 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Death 28c. Injury at Work? 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 1 Naturel 5 Pending 1 Yes Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homlcide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred et the time, date and plece, end due to the cause(s) end menner stated. 29e. Certifier

Examiner P.O. Box 68760, Records. Division of Vital

The law requires that the death certificate be executed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, i

Physician

/Medical

Examiner

Funeral

Director

must be notified at

7 is marked other than "natural", or items traumatic event, the Magical Examiner m

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page 2

certificate

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Certification:

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permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Inportant: If Item 27 is marked other than "natural", or item

Baltimore, Maryland 21215-0020

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State Registrar

eputy 30 Name

29c. License number

29d. Date signed (Month, Dey, Year)

and address of person who completed ceuse of deeth (Item 23e) (Type, Print)

32. Registrer's Signeture

TONES, MO

DEC

29b. Signeture and title of certifier

31. Dete filed (Month, Dey, Year) 2 7 2000 THE RESIDENCE OF THE PROPERTY OF THE PARTY O

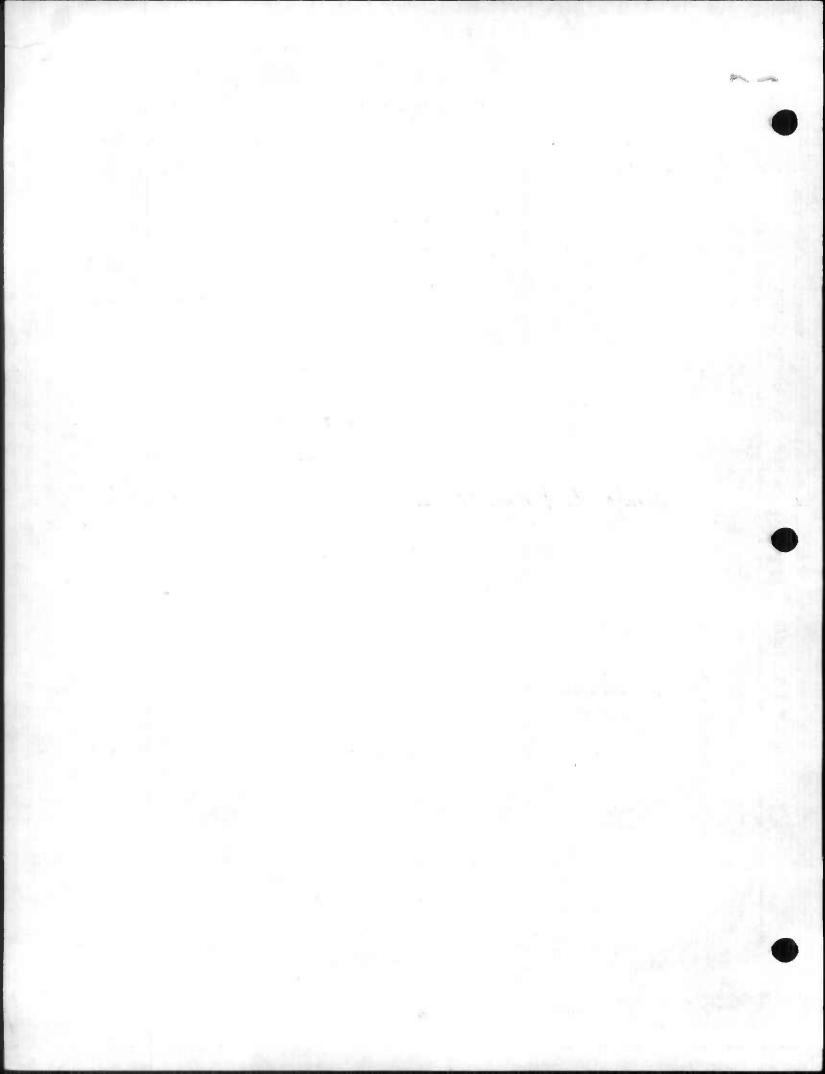
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State of Maryland /	Department of	f Health and Mental Hygiene	01

43562 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 **Physician** Andres Neftaly Gonzalez 31 4:13 AM 2000 /Medical 4a Fscility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly, P.G. Community Hospital Prince George's MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 09-03-47 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1X M 2 F Months Days Hours 53 547-73-9704 El Salvador Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f ahow 1 ☐ Yes 2 No DC Director Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 1457 Harvard Street, N.W. 20009 El Salvador Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 270 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married Baltimore, Maryland 21215-0020 Mary Yes 2 No Specify: El Salvadoran Specify: Hispanic Completed by 3 ☐ Widowed 4 ☐ Divorced Hygiene. other than "naturnent, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Janitor Warehouse 3rd 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pagas 1 and 2 should be file Department of Health and Mentel Hy Important: if them 27 is marked other any Injury or other traumatic event bace. Be Rosendo Flores Unk. Maria 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14213 Grand Pre Road, #104 Leticia Gonzalez Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Inglewood Park Cemetery 1/12/01 4 ☐ Donation 5 ☐ Other (Specify) Inglewood, Calif 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Bacon Funeral Home, Inc. Bacon CCD 36/ 3447 14th Street, N.W. Washington, D.C. 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Resperatory Facluse **Examiner** Physician/Medical Examiner hysician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Melleties 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 20 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1□ Yes 2Q No After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury st Work? or Attending 5 Pending Investigation within 24 hours after deeth.
To the Funeral Director: All completely filled in by the fu 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

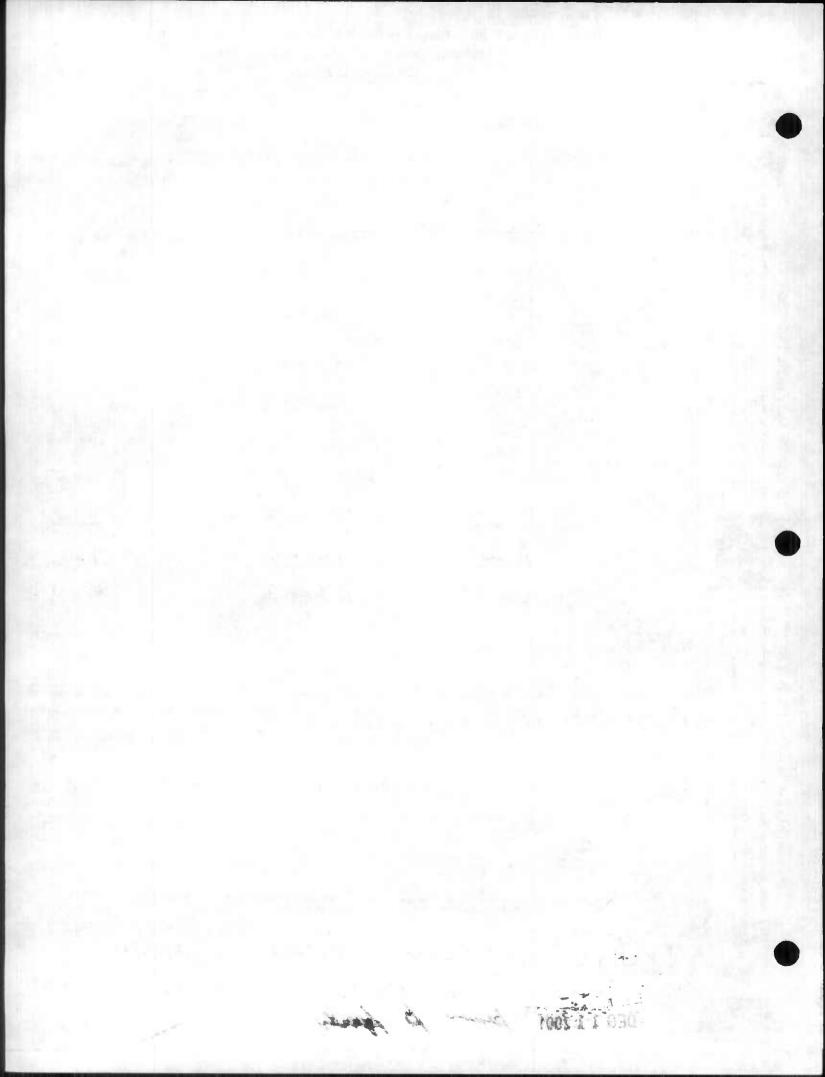
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Well. 1 December 31, 2000 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) prince George's Hospital Conter Cheverly, and Jerel M. ZOUTLLE MS 31. Date liled (Month, Day, Year) 32. Registrar's Signature State JAN 1 0 2001 Registrar Sporks

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 43563

				Certificate of	Death	Reg	j. No.	
	Physician	1. Decedent's Neme (First, Middle, Last)	S-IFT IV.			2. Date of Death Month	Dey Yo	3. Time of Death
	/Medical Examiner	E. ROBERTA HAYE 4a Facility Neme (If not institution, give str			4b. City, Town, or Loc	DEC. 26		6:00 am
6	LAdillilei	1207 VAN BUREN	CIRCLE	Table Comme	ANNAPOLI:	S	ANNE A	RUNDEL
Г	Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. les	t birthday) If Under 1 Year		8. Date of Birth (Month, Dey,)		Birthplace (Stete or Foreign Country)
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	vith the Ma or 28s-f s be notified	1ARYT, AND ANNE AR 10e. Street and Number	UNDEL ANN	APOLIS 10f. Zip Code		109	g. Citizen of Wha	at Country?
	rai [27 LINCOLN PARK		2140				SA
020	urs efter L', or the Example by Ful	11. Marifel Stefus 12 1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No lit Yes, Give Year or Dates:	13. Wes Decedent of H If Yes, specify Cube 1 ☐ Yes XCXNo	en, Mexican, Puerto F	cify Yes or No- Rican, etc.)	Black,	American Indian, White, etc. BLACK
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pu	tal Hyginal Hyginal dother event, I Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Ma	aiden Sumame)	
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Maryjand	d 2 sh th end 7 la rr traum	19a. Informant's Name/Relationship (Type WILLIAM HAYES (H		19b. Meiling Address (Street 27 LINCOLN			-	
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mo	Peges nent of I mt: If Ne iry or o	133 Burial 2 ☐ Cremetion 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	etery, cremetory or other please. YLAND VETER		/2/01 0	DOLINGS	TLLE. MD.
Baitimore	permit. Peg Department Important: I any Injury o	21. Signeture of Funerel Service Licensee	MAR	22. Name and Addre	ss of Facility			
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ر.	ned by e deta	Endoscopic chol	ecystectom	1 12/22		1 Yes	2 2 No 3	☐ Probably 4 ☐ Unknown
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State Registrar

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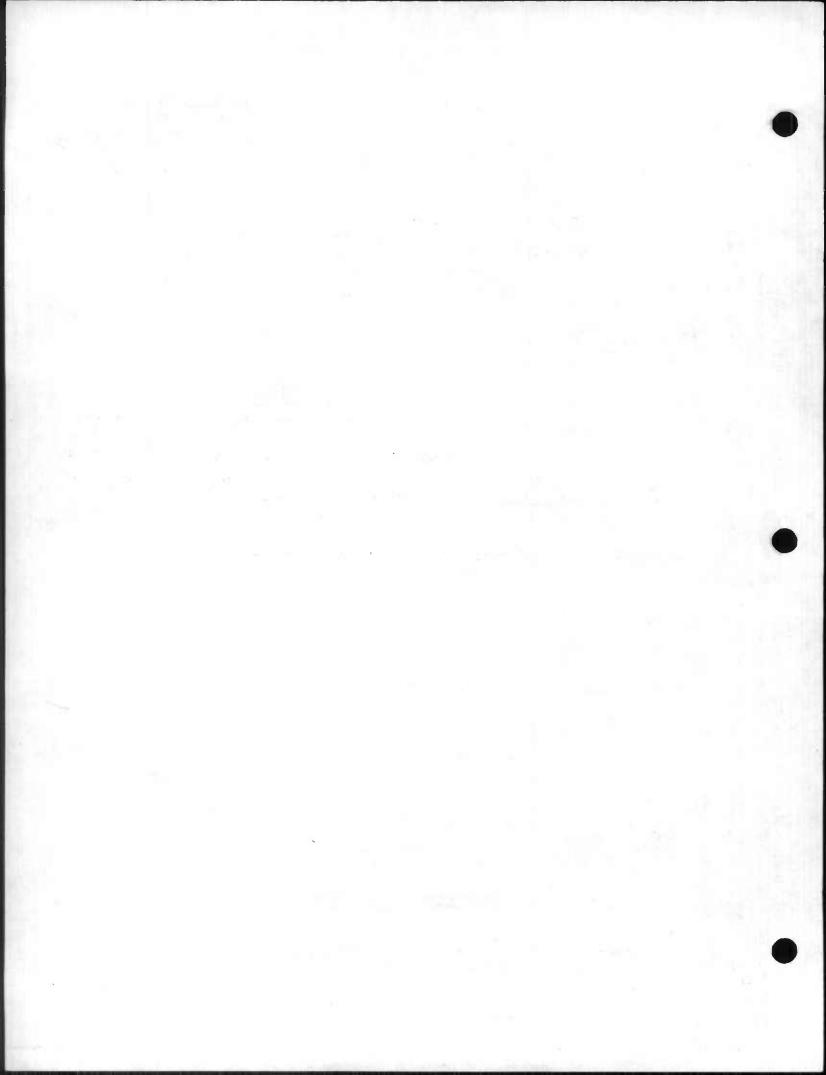


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State of Maryland / Department of Health and Mental Hygiene 4 3 5 6 5

			Cert	ificate of	Death	R	ng. No.		
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Funeral	Social Security Number 6. S	D		If Under 1 Year Months Days	If Undar 24 Hrs Hours Min		Year)	9. Birthpta	ca (Stata or Foraign
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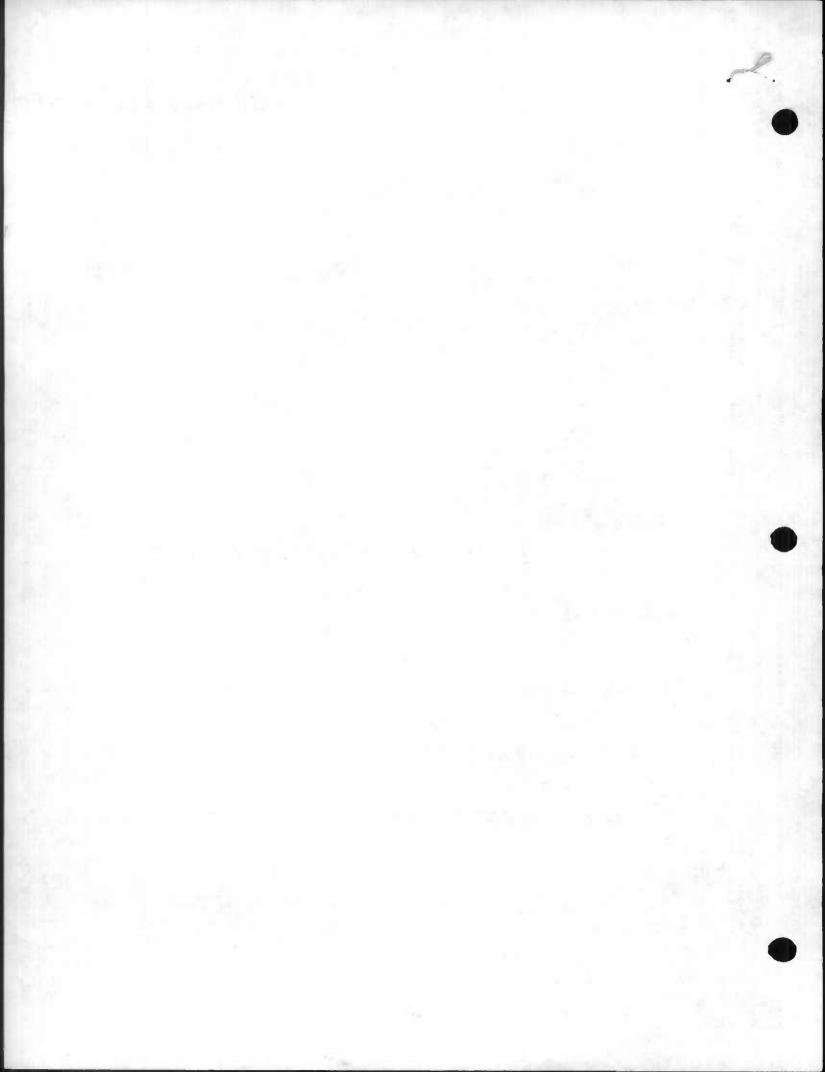
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U U +3567Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 30, 2000 **Physician** 6:50Pm Sidney Robert Tinney /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arunde If Under 1 Yeer | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Hours 11XM 2□ F Yrs Washington, DC **Director** 579-86-8752 Nov. 3, 1958 Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Director 288-1 Washington, DC DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20017 190 36thST NE USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. 14. Race - American Indian, 11. Mentel Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Damons Transprotation 10th Transporter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Georgian Belt Robert A. Tinney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 nent of Health a nt. If Nem 27 is y or other Anna M. Tinney/Sister 1381 Desota Ave., Atlanta, GA 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01/06/01Landover, Md. Harmony Memorial 21. Signature of Funeral Service License 22. Name and Address of Facility Robert G. Mason Funeral Home 1661 Good Hope Rd. SE, Washington, DC 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, about, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** fmmediate Cause (Final disease or condition resulting in death) /Medical HOUTE RESPIRATORY FAILURE Examiner Due to (or as a consequence of): Physician/Medical Examiner TIC 5HDCK
Due to (or as e consequenca of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last TUTE PUL MONTRY EDEMA
Due to (or es e consequence of): ROSEPSIC Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 23b. Did tobacco use contributs to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown MELLITUS by of Vital Records, 24a. Was an autopsy performed? 24b. Were eutopsy findings available prior to Be Completed REMAL INSUFFICIENCY completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ 60 NEMIF 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: De Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? at or Attending P s after death.

I Director: After to in by the funer. 1 Natural 2 Accident 5 Pending investigation Division 1 Yes 2 No 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner stated. 29a, Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DECEMBER 30, 2000 D51664 HOSPITAL DRIVE, GLENBURNIE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 0 2001 Registrar **DHMH 16 Rsv 6/95**

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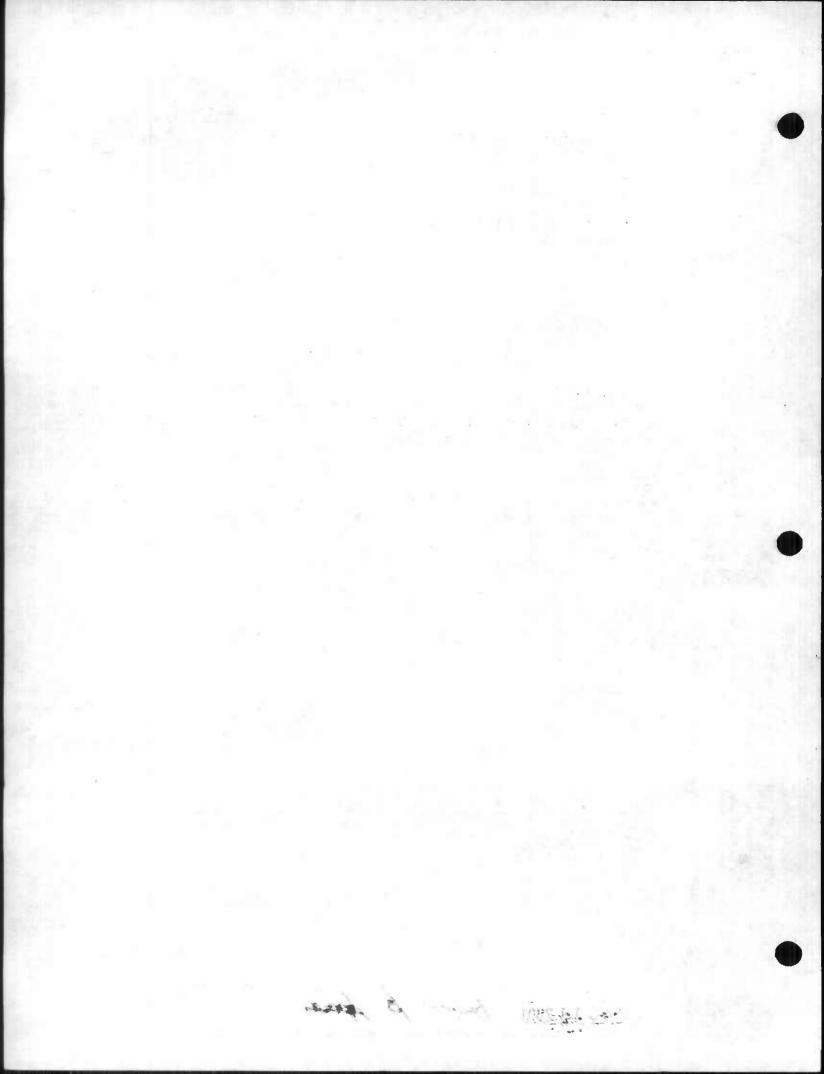
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State of Maryland / Department of Health and Mental Hygiene 0 0 4 3 5 6 8

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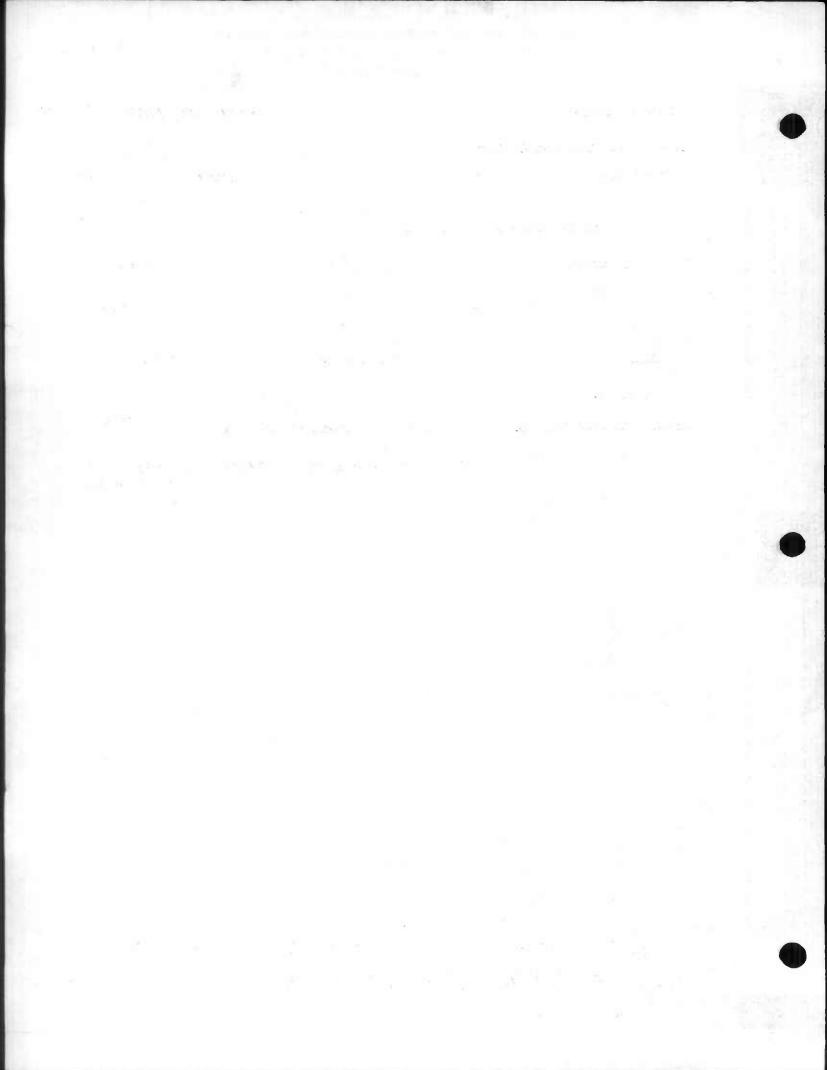
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00-7310-001 Please Type or Print in Black Indelible Ink. Ensure All Coples Are Legible. B.K.S State of Maryland / Department of Health and Mental Hygiene EARL WATKINS REPLACEMENTI-Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Earl Watkins OCT 21, 2000 11:25 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** WESTERN CORRECTIONAL INSTITUTION CUMBERLAND ALLEGANY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 ₺ M 2 🗆 F 71 04/01/1929 215-51-8104 MD Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits worde r 28a-f show MD Allegany Cumberland 1 XYes 2 No Director 10e. Street and Number 13800 McMullen Highway 10g. Citizen of What Country? 10f. Zip Code r than "naturel", or iteme 23s or the Medical Examiner must be 21502 U.S. deeth 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status hours efter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working unk life. DO NOT use retired) filed within 72 h I Hygiene. 16b. Kind of Business/Industry ımk Elementary/Secondary (0-12) Cottege (1-4or 5+) unk unk other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental 27 ie marked c traumatic ev 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Western Correctional Institute 13800 McMullen Highway Cumberland, Maryland 21502 Health Hem 27 I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of the Important: If its eny injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 ☑ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityState Anatomy Board 655 W. Baltimore St. Ronald S. Wade, Director per DVR Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PULMONARY EMBOLISM /Medical Due to (or as a consequence of) Examiner IMMOBILITY FROM FRACTURE OF TIBIA Sequentially llst conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The lew requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of deeth 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown by the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did fobacco use contribute to the causa of death? Division of Vital Records, þ Diabetes Mellitus 1 Yes 2 No 3 Probably 4 Unknown been sir Completed Hypertensive Arteriosclerotic Cardiovascular Disease 24b. Were autopsy findings available prior to completion of ceuse of death?

1 Yes 2 No 24a. Was an certificate has l autopsy perform page 1 Yes 2 No Physicien: 25. Was case referred to medical Be 28. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28c. Injury af Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: After or Attending 1 Natural 5 Pending 8/25/00 death. UNKNOWN M 1 ☐ Yes 2 ☑ No investigation SUBJECT FELL filled in by the f 2X Accident 28e. Place of Injury - At home, farm, street, factory, office determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

PRISON

28f. Location (Street and Number or Rural Route Number, City or Town, State)

WESTERN CORRECTIONAL INSTITUTE

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

WESTERN CORRECTIONAL INSTITUTE

1 Settifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

WESTERN CORRECTIONAL INSTITUTE

1 Settifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 6 ☐ Could not be 3 Suicide 4 Homicide within 24 hours a To the Funerel L 29a. Certifier Medical (Check only one) and manner stated. To the 29b. Sigryn 29c. License number 29d. Dete signed (Month, Day, Year) O.C.M.E FEB. 15, 2001

State Registrar ath (Item 23a) (Type, Print)

111 PENN STREET, BALTIMORE, MARYLAND 21201

taner

Registrar's Signature

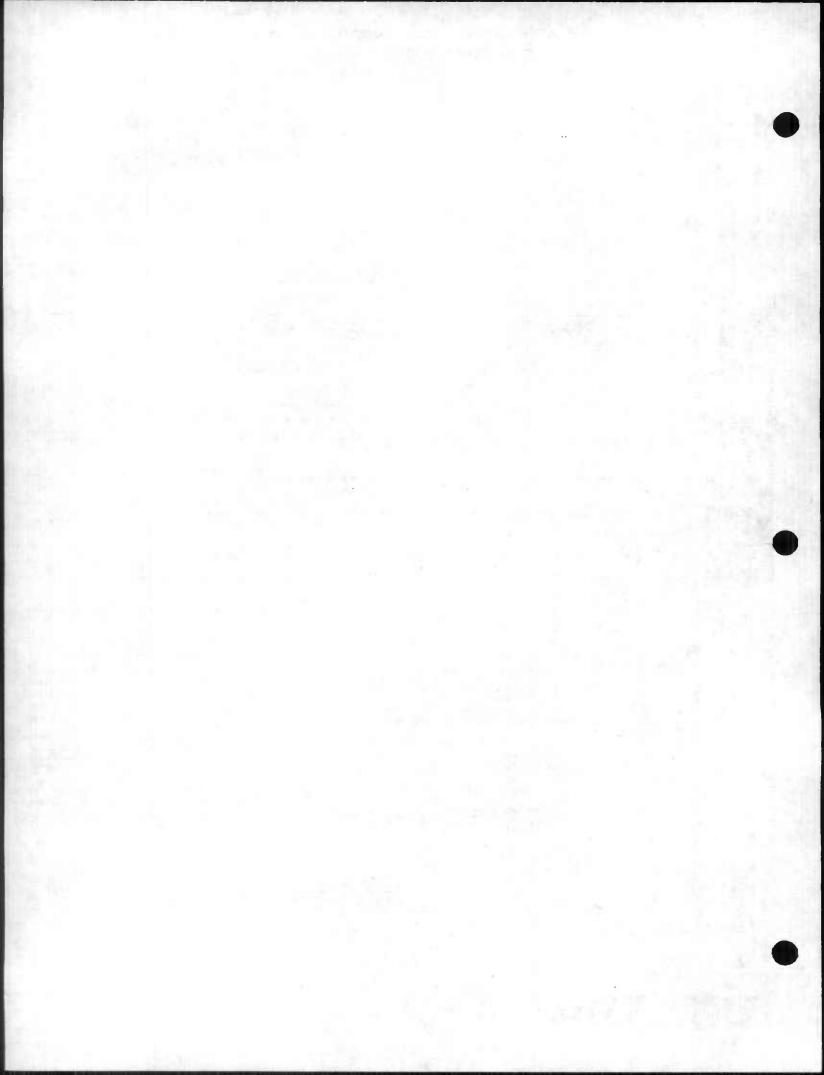
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and address of person who completed cause of de

2001

th, Day, Year

31. Date filed



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ICHARD 80. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death 20 BAT If Under 24 Hrs. MARY LAND mule UNIVERSITY 5. Social Security Number MEDICAT Baltimore 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Min Hours 1 M 2 F Yrs. 62 218-34-3273 5, Jan. Maryland Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Wicomico Parsonsburg 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 31718 Morris Leonard Road 21849 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give 1956-60

Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHite 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Custom Home Builder Lumber 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William S. Adkins Mildred E. Morris Adkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Adkins, Wife 31718 Morris Leonard Road, Parsonsburg, Md. 21849 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Grove Cemetery 1-2-2001 Parsonsburg, Md. 21. Signature of Funeral Service Licensee 22. Neme and Address of Facility Short Funeral Home, Inc. 23a. Part I Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 13 E. Grove St. Delmar, De. 19940 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): ANC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (dr as a consequence of): AS bestos Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 20 No 1 Yes 2 No 1 Yes 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No

Examiner physician and the burief-transit law requires that the death certificate be executed for use as 2 signed by the a 0 Records. peeu page 2 certificate has The Division of Vital Physician: this funeral After or Attending in 24 hours after death.

the Funeral Director: After the funeral in by the funeral control of the funeral control within 24 hor To the Fune completely fi

Physician

/Medical

Examiner

Funeral

Director

28a-f show must be notified at

"natural", or flams 23a

marked other than

permit. Pages 1 and 2 should be the Department of Health and Mental Hy Important: If Nem 27 is manked other any Injury or other traumatic event

Physician

/Medical

Examin

Physician/Medical

by

Completed

Be

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Certification:

2 Accident

3 Suicide

29a. Cartifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Baltimore,

Hygiena

the Medical Examiner

Director

Funeral

þ

Completed

Be

Md.

12

edical GExchay

State Registra

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

0

RESIDENT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

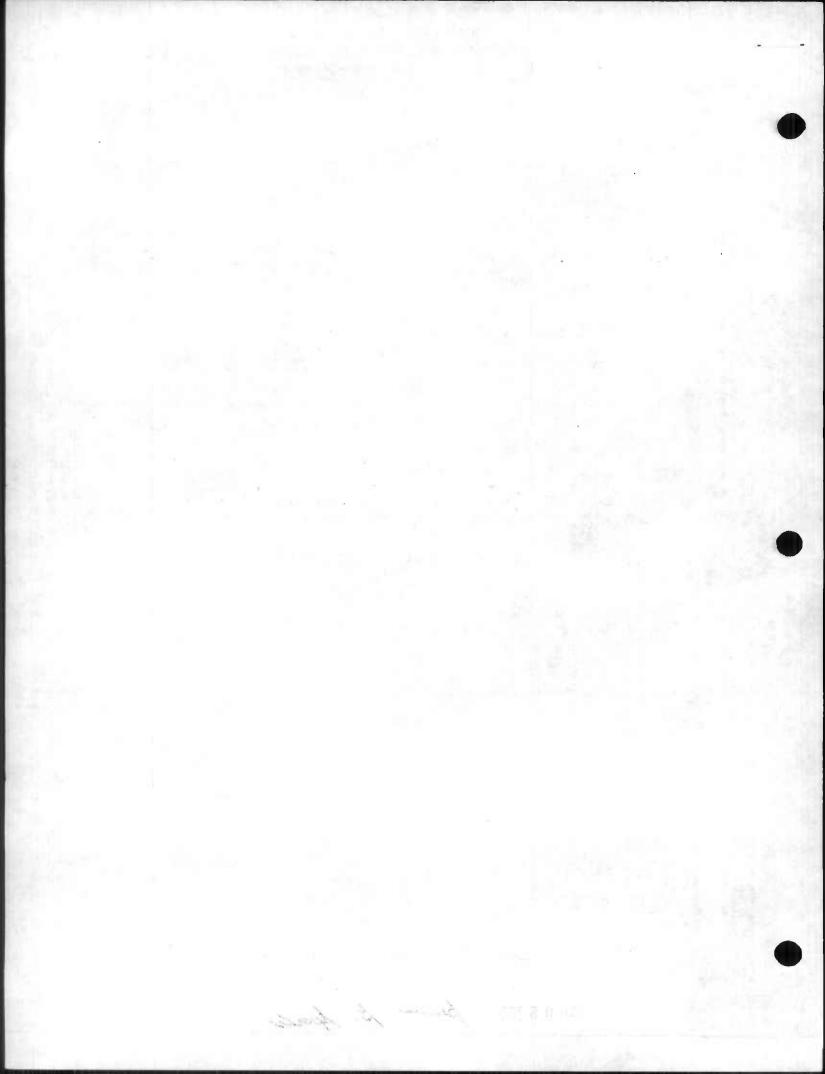
Street SOUTH Green

32. Registrar's Signature 31. Date filed (Month, Day, Year) JAN 0 5 2001

6 Could not be

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 4 3 5 7 2 AMEND ITEM: 23 PART I PER PHY G792 2-1-01 We ertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Patricia M. Bradley-McClure Dec. 2000 14, 1325 /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days 1 ☐ M 2 ☑ F 50 Yrs 194-40-6603 Director May 11, 1950 WV Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Spermit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Coppartment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or theme 23a or 28a-f show any linjury or other traumatic event, the Medical Economic must be notified an bonds. 1 ☐ Yes 2 No Anne Arundel Glen Burnie Director 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7947 Parke West Drive 21061 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Black, White, etc. 1 Yes 20 No If Yes, Give Year or Dates: 1 Never Married 2 Merried Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Bustness/Industry Elementary/Secondery (0-12) College (1-4or 5+) Home Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Patrick Bradley Cyrilla Soisson 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven McClure/Husband 7947 Parke West Drive, Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Dec 19 1 Bunal 2 Cremetion 3 Removal from Stele
4 Donetion 5 Other (Specify) Baltimore, MD Metro Crematory 2000 22. Name and Address of Fecility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

Part Enlar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate Interval Between Onset and Deeth GASTRIC HEMORRHAGE **Physician** Immediate Cause (Final disease or condition resulting to death) /Medical hours emorra Examiner Due to (or as a consequence of): GASTRIC ULCER Exami Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last ician and buriel-tran Due to (or as a consequence of): signed by the attending physician the detached for use as the burie Physician/Medical Due to (or as a consequence of) Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 22 No 3 Probably 4 Unknown VUI þ Records. 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No OL 27. Manner of Death 28c. tnjury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Attending 5 Pending investigation 1 Natural death. 1 Yes 2 No 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Mospital o within 24 hours a
To the Funeral
Completely filled edicai Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ad D0032869 Haved (Barner Up) 30. Name and address of person who completed ceuse of death (ttem 23a) (Type, Print) 2003 Medecol thery, Annopoles ud 21401 David C. 31. Date filed (Month, Dey, Year) 32. Registrar's Signature

State Registrar

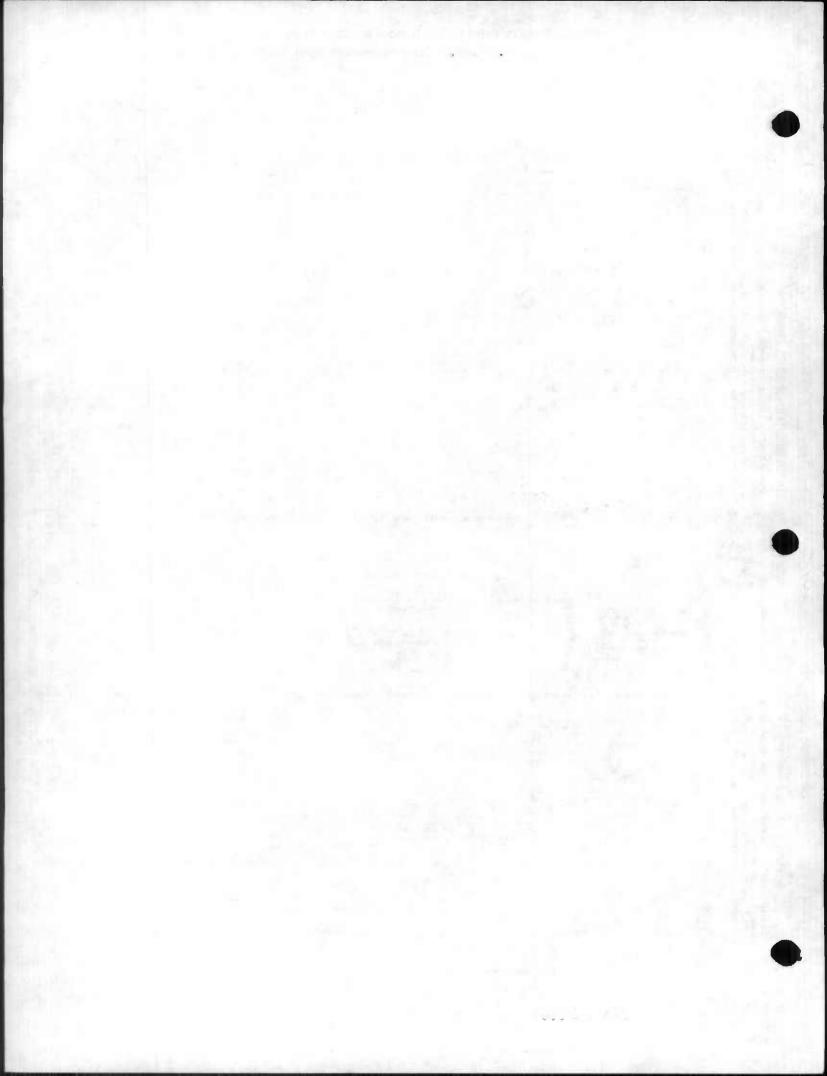
DEC 18 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene ADMEND ITEM: #26 PER PHY G793 3-17-01 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dec **Physician** 0415 2000 MARTIN WILLIAM DEVLIN /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** BERLIN If Under 24 Hrs. ATLANTIC GENERAL HOSPITAL WORCESTER If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 12 M 2 F Months Days Hours Min Yrs. 213-01-0319 84 Director 4-20-16 D. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Instde City Limits or 28a-f ahow Mp. Yes 2 No WORCESTER OCEAN CITY Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 122 S. OCEAN DRIVE 21842 U.S.A. 238 12. Was Decedent Ever In U.S. Armed Forces? ↑ Dayes 2 □ No KYes, Give Year or Dates: WW I Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 11. Maritai Status 1 Never Married 2 Married ò 1 ☐ Yes 2 ☑ No Specify. Specify: WHITE WWII by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Etementery/Secondary (0-12) College (1-4or 5+) BCFD LIEUTENANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be financial Mental H DEVLIN GERTRUDE O'CONNOR MICHAEL 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Retationship (Type, Print) 122 S. OCEAN DRIVE OCEAN CITY, MD. DELORES DEVLIN Haalth em 27 i artment of Haal ortant: If item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cremation 3 Removal Irom State
4 Donation 5 Other (Specify) BALTIMORE MD. 1-7 DULANEY VALLEY 22. Name and Address of Facility Depar impor eny in ULLRICH FUNERAL HOME BERLIN , Mp. 21811 23a Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Braingum Examiner Due to (or as a consequence of): hours Physician/Medicai Examiner ntracranial The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last and per tension Due to (or as a consequence ol) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown - brillation þ Aftar this certificate has been signed funeral director, page 2 should be 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth? Medical Certification: To Be Completed 1 Yes 2 No 1 Yes 2 No dal or Attennament and the formal and formal 25. Was case referred to medicat 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury et Work? 1 Matural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital
within 24 hours
To the Funerel Completaly filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D47698 ollety MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AGHER - 9733 Healthouty Dr. Birlin MD Geraldine ertzen 31. Date lited (Month, Day, Year) JAN 01 200 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 43574

		Certificate of Death	Reg. No.	400/4						
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Examiner	4a Facility Nama (If not institution, give street and number)	4b. City, Town, or Loc	cation of Death 4c. County of E	Death /						
	236 Cake share Dr.	Oakla	nd Garre	tt						
Funeral	5. Social Security Number 6. Sex 7. Aga (In yrs. last birt	thday) If Undar 1 Yaar If Undar 24 Hrs. Months Days Hours Min.	8. Data of Birth (Month, Day, Year)	Birthplace (State or Fore Country)						
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or 28a-f s be notified Director	10e. Street and Number	10f. Zip Code	10g. Citizen of Wha	t Country?						
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L A	21. Signature of Funaral Sarvice Licensee	22. Nama and Addrass of Facility Har	tzler Funeral Ho	ome						
25.60	Catharine V. Workler	6 E. Broadway Uni	on Bridge, MD 2:	1791						
	23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one ceuse on each line.	not entar tha moda of dying, such as cardiac or	r raspiratory arrast,	Approximata Interval Between						
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To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Cartifier 15 Certifying Physician: To the best of my knowledge.									
To the Funeral Director: A completely filled in by the f	(Check only one) 2 Medical Examiner: On the basis of axaminetion end and manner steted.	d/or investigation, in my opinion, death occurre	d at the time, data and place, and	due to the cause(s)						
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 amend item 26 per md G792 2/8/01 yf Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month Year **Physician** MICHAEL JOSEPH FEIFER JR. 21 2000 1943 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Name (If not institution, give street and number) Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Deys Hours 100 M 2□ F 172-34-9063 57 1/23/1943 Director PENNSYLVANIA Usual Residence of Decedent the Merylend 10c. City, Town or Location 10d. Inside City Limits 10e State 10h County 7 is marked other than "natural", or items 23s or 25s-f ahow traumetic avant, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director QUEEN ANNE'S STEVENSVILLE 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? 106 VIRGINIA ROAD 21666 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 X Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0020 Specify: Specify: WHITE A 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nit. Pages 1 and 2 should be filed within artment of Health and Mental Hygiene. ortant: If Item 27 Is marked other than Injury or other traumetic event, the Me. Elementary/Secondary (0-12) College (1-4or 5+) DIRECTOR OF BANKING BANKING 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) MICHAEL FEIFER SR. JULIA KIDDON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 106 VIRGINIA ROAD STEVENSVILLE, MD 21666 DIANE FEIFER / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ABuriei 2 Cremation 3 Removal from State Department of Important: If any Injury or PETERS CEMETERY 12/27/00 OUEENSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur & Juperal Service Licenses 22. Name and Address of Fecility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 106 SHAMROCK ROAD CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** 1/4 /Medical Immediate Cause (Final Molard ial disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of) the as USB Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. 2 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy Completed peen page 2 certificate has 2) No 1∏ Yes 1 □ Yes 2 □ No or Attending Physician: after deeth. Diractor: After this certifica 25. Was cese referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☒ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation 1-Naturai 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital of 24 hours a Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner steted. edical 29a. Certifier To the I within 2 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number

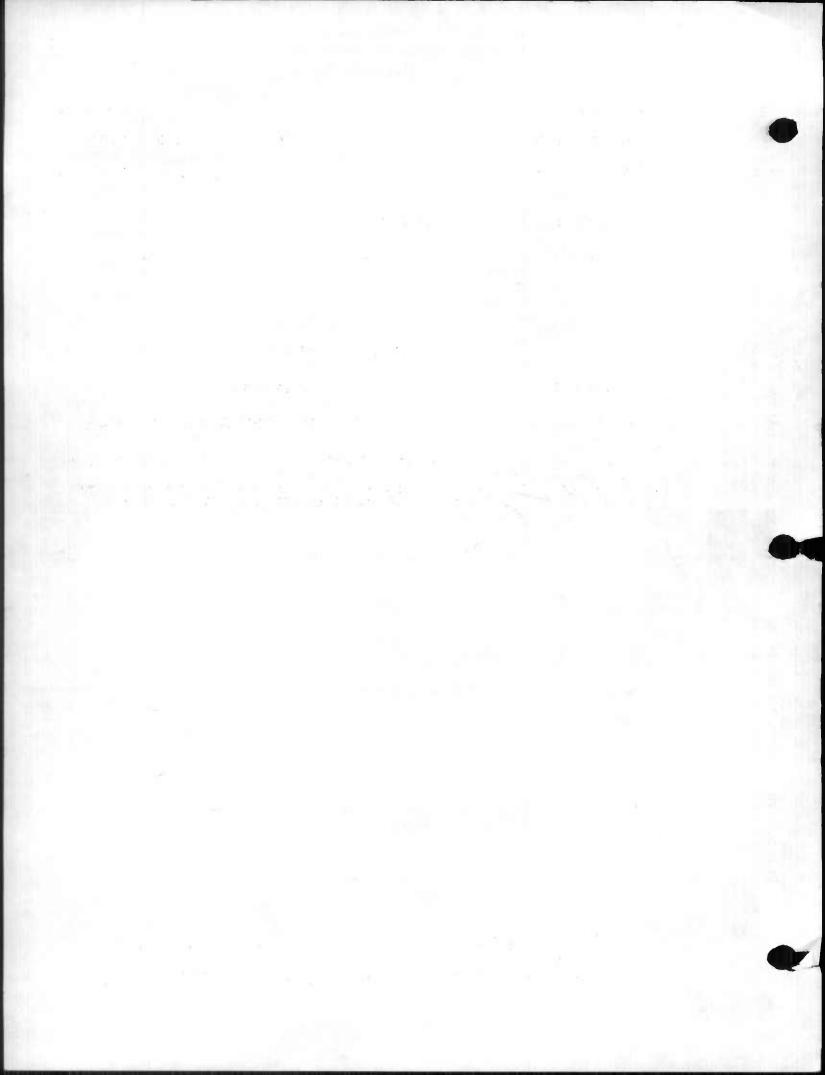
State Registra 31. Date filed (Month, Day, Year) DEC 2 6 2000

30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) prone

> 32. Registrar's Signeture Benera

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Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tim f th Month 2000 December 30 1425 VIRGINIA R. FREEMAN 4b. City, Town, or Location of Death 4c. County of Death

Examiner **Funeral**

Director

with the Marylend

death

filed within 72 hours efter

Baltimore, Maryland 21215-0020

Physician

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, its Moulcal Examiner must be notified at Directo Funeral þ Completed Hygiane.

permit. Pages 1 end 2 should be file Department of Health and Mental Hyr Important: If Item 27 is merked other any Injury or other traumatic event, DDCs. Physician /Medical Examiner

Examiner physician end s the buriel-trans Physician/Medical usa ed by the detached signed t þ Completed pege 2 funeral director, Be 2 this Certification: after death. Director: Aft

1 Naturel

2 Accident

4 Homicide

(Check only one)

3 Suicide

29a. Certifier

Division of Vital Records, P.O.

Attending Physician:

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Hospital 24 hours a Funeral D Medical within 2 To the 2

Registrar

/Medical 4a Facility Name (If not institution, give street and number) Shady Grove Hospital Gaithersburg Montgomery If U r 1 Y r If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 🗓 F Months Yrs. Feb. 12, 1922 Washington DC 78 578 20 8573 Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Rockville ty Yes 2 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20850 1235 Potomac Valley Road USA 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: White 3 □XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Sales Clerk Private 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Susie Spencer William L. Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Baumgarten/daughter 718 West John Street Martinsburg, W. Virginia25401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-5-01 Suitland, Maryland Cedar Hill Cemetery 22. Name and Address of Facility MARSHALL S FUNERAL HOME OF MD 21. Signature of Funeral Service License MD 20746 234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one ceuse on eech line. **Approximate** Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24a. Was an autopsy performed? 212 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 1 ☐ Yes 25 No 27. Menner of Deeth Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

> 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) and manner as stated.
>
> 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier

5 Pending

JAN 0 3 2001

investigation

6 Could not be determined

29c. License number

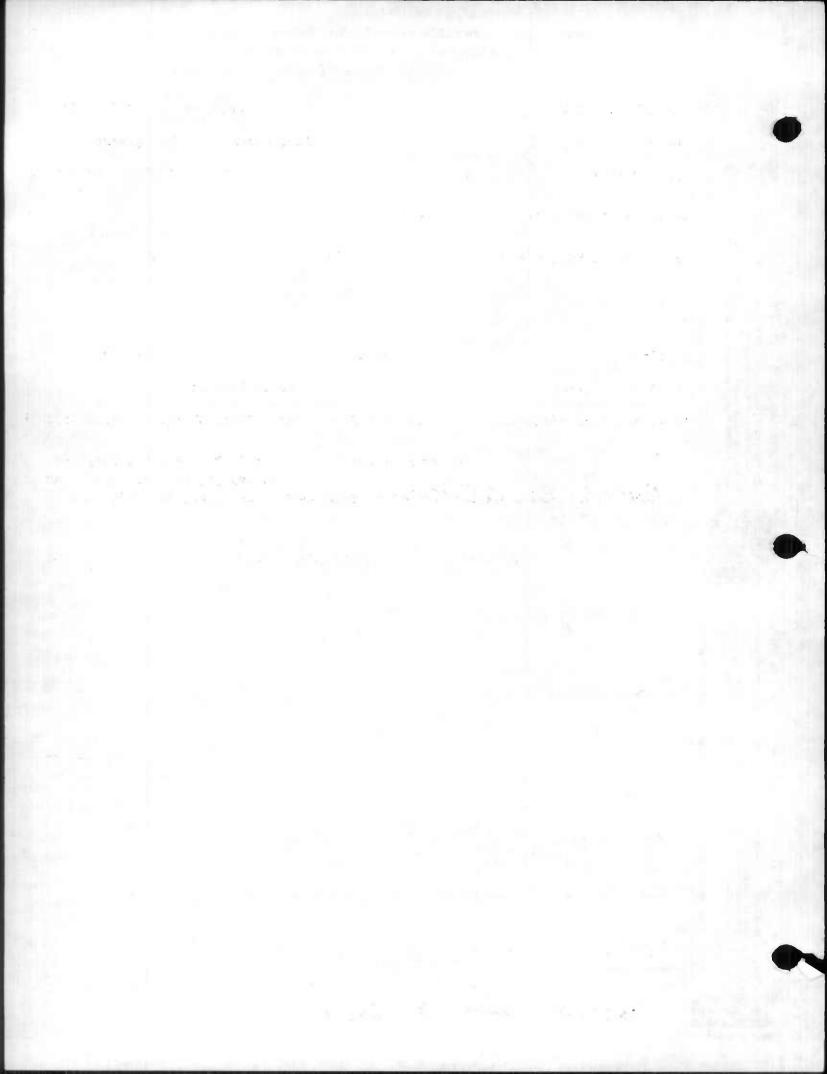
1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 30, 2000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Patricia L. Tomsko, MD, 11140 Rockville Pike, PMB 348, Rockville, MD 20892 31. Dete filed (Month, Day, Year) 22. Registrar's Signature

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. ADMEND ITEM: #27 PER PHY G793 3-17-01 WR. Cortificate of Dooth Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Alicia Yvette Gee 9:36 p.m. Dec. 2000 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Kent & Queen Anne's Hospital Chestertown Kent If Under 1 Yeer Months Deys If Under 24 Hrs. Hours Min. 8. Dete of Birth (Month, Day, Year) 6-16-19/1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2∰F 217-78-8393 29 Director MD Usual Residence of Decedent filed within 72 hours efter deeth with the Maryland 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "naturel", or items 23a or 28s-f show the Medical Examiner must be notified at MD Kent Chestertown 1 ☐ Yes 2 4 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 22402 Cross Road 21620 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Meritel Stetus Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 1 Never Merried 2 Merried 1 Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorcad Black 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/industry el Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Special Ed Disabled Disabled permit. Peges 1 and 2 should be file Department of Heelth and Mentel Hy Important: if item Z7 is marked othe any Injury or other traumatic event ODGs. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Claiborne Gee Alice Blake 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia Griffin - Aunt 22402 Cross Rd., Chestertown, MD 21620 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ♥ Buriei 2 □ Cremation 3 □ Removel from Stete Asbury Cemetery 12/16/00 Chestertown, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility James A. Perkins Funeral Service P.O. Box 143, 21106 Rock Hall Ave., Rock Hall, MD 21661 ames a Terkins 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting In deeth) /Medical Psendomonas aspiration Examiner Due to (or es a consequenca of) Examiner abdominal the ettending physician and hed for use es the bunal-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in deeth) Lest Taphylo Locus

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 24 hours e
 Funeral D edical 1 Sertifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end pleca, and due to the cause(s) end menner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one)

Registrar

redrick Delboy 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture 2000

30. Name and eddress of person who completed cause of deeth (item 23a) (Type, Print)

M.D.

29b. Signeture end title of cartifier

29c. License number

DO05 1735

29d. Dete signed (Month, Day, Year)

Eleoa Cheirchhell Road Chestertown MD

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O.

AMB. A STATE

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland (Pepartment of Health and Mental Hygiene UU AMEND ITEM: #23 PART I PER PHY G791 2-1-01 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 2000 Carrie Elizabeth Holt 8:34 PM 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 7, 1918 Birthplace (State or Foreign Country)
 Mary Land 7. Age (In yrs. last birthday) Hours Months 1□ M 2XF Yrs. 82 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No St. Mary's Morganza 10f Zip Code 10g. Citizen of What Country? 20660 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Datas: 1 ☐ Yes 2 ☑ No Specify: Specify: Black 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Cottege (1-4or 5+)

or 28a-t hems 23a 8 Maryland 21215-0020 Pages 1 and 2 should be nent of Health and Mental is marked portant: If Item 27 Saltimore,

Physician

/Medical

Examiner

Funeral

Director

Rhysician /Medical Examiner

The law requires that the death certificate be certificate has director, this After t after death

Records.

Division of Wital

Hospital or 24 hours

To the vithin 2

Physician/Medical Examiner à Be Completed Certification: To illed in by edical

St. Mary's Hospital 5. Social Security Number 214-18-8650 Usual Residence of Decedent 10a. Steta Maryland 10e. Street and Number 급 26423 Morganza Laurel Grove Road Funeral 1 Never Married 2 Married 3 DWidowed 4 □ Divorced Elementary/Secondery (0-12) 8th Private School Cook 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymos Medley Lucille Mason 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) P.O. Box 62, Morganza, MD 20660 Evangeline B. Holt (Daughter) 20b. Ptece of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, Stete cemetary, crematory or other place) 1 Buriel 2 □ Cremation 3 □ Removet from State Charles Memorial Gardens 11/9/00 Leonardtown, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 22. Name and Address of Fecility. Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, I 23a. Pert1. Enter the disease or complications that caused the down. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. P.O. Box 270, Leonardtown, Maryland 20650 Approximate Intervet Between Onset end Death Immediate Cause (Finel disease or condition resulting in deeth) cardio-pulmonery arrest mortes Due to (or es e consequence of) Months stage reval Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Lest Due to (or es a consequence of): DIABETES MELITUS Dua to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 | Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Ves 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not ba determined 3 ☐ Suicida 28l. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 16 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier (Check only one)

State Registrar

JEFFERY BROWN M.D 31. Dete filed (Month, Dey, Year) NOV 8 2000

30. Name and address of person who completed cause of deeth (ttem 23a) (Type, Print)

29b. Signators and title of certifier

32. Registrer's Signeture

23000 MOAKLEY STREET SUITE 201 LEONARDTOWN, MD. 20650

29c. License number

D42597

29d. Date signed (Month, Day, Year)

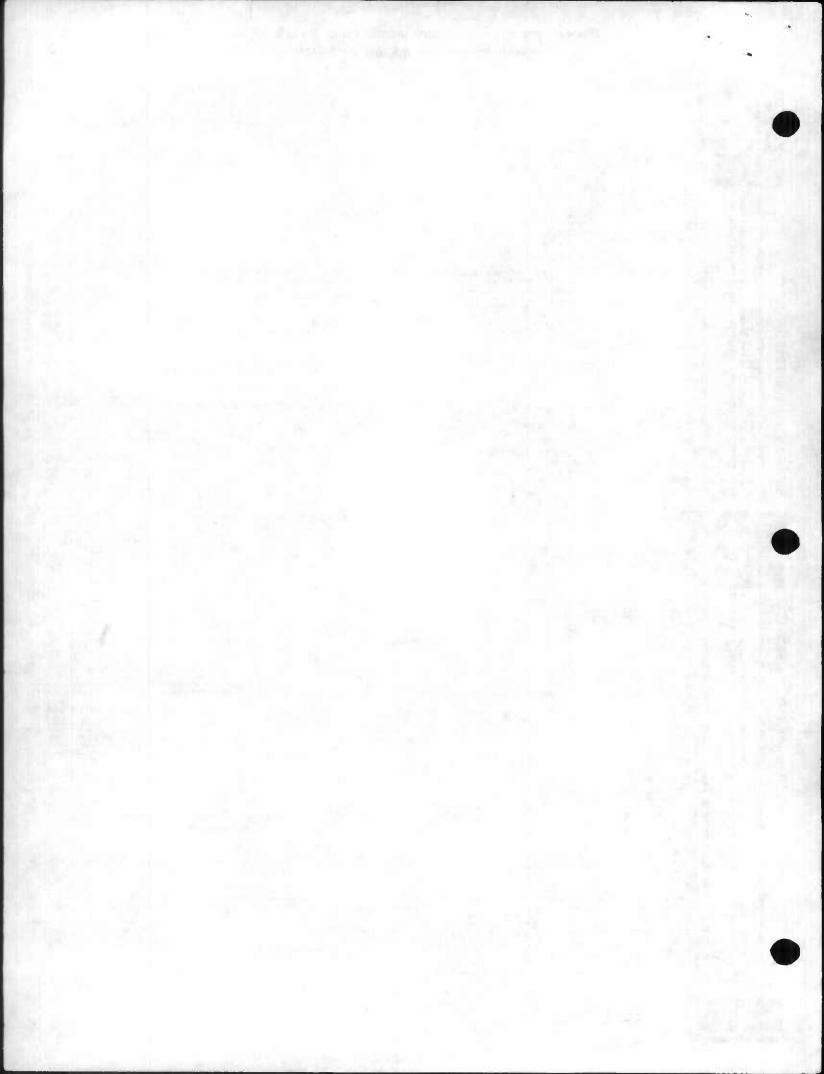
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SEE YEAR

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State of Maryland	Department of	Health and I	Mental Hygiene	U	
DITTE 0700 0'4 04	an name				

F	AMEND ITE	M: 23 PART I, PER PHY G792 2-1-01 Wentificate of Death	Reg. No.	
		The state of the s	2. Data of Death	3. Time of Death
	Physician	Marie Elizabeth Hock	September 6,	2000 10:40 PM
	/Medical	4e Facility Nema (If not institution, give street and number) 4b. City, Town, or Loc		
	Examiner	3004 North Ridge Rd., #408 Azalea Ct. Ellicott (to the same of the	
-	5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yeer If Undar 24 Hrs.	8. Date of Birth (Month, Dey, Year)	9. Birthplace (State or Foreign
	Funeral Director	214-12-6279 1 M 2 F 82 Yrs. Months Deys Hours Min.	Jan. 3, 1918	Maryland
	B 2	10a. Stete 10b. County 10c. City, Town or Location		10d. Inside City Limits
	with the Marylar a or 28e-f show be notified at Director	Maryland Howard Ellicott City		1 ☐ Yes 2 🛣 No
	or 25a-fa be notified Director	10e. Street and Number 10f. Zip Code	10g. Citizen of V	What Country?
	Sa or	3004 North Ridge Rd., #408 Azalea Ct. 21043	U.S.A	
	Sent The 2	11. Maritel Status 12. Wes Decedent Ever in U,S. 13. Was Decedent of Hispanic Origin? (Spe	ecify Yas or No- 14. Rac	ca - American Indien,
020	af, or he Examine by Fur	Armed Forces? If Yes, specify Cuban, Mexican, Puarto F 1 Nevar Merried 2 Merried 1 Yas 2 No If Yes, Give 1	Hican, etc.) Black	ck, White, etc. Y: White
2-0	ad within 72 ho ygiene. yr than "naturn rt, the Medical Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working the completed)	16b. Kind of B	usiness/Industry
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Pu	Be Be		(First, Middle, Meiden Sumen	ne)
ya	Mental H Mental H arked oth attc aven To Be	Joseph Walter Marousek Catherin	ne Rose Era	
, Maryland 21215-0020	aith and 27 is m r traum	19a. Informant's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rura 19b. Melling Address (Street and Number or Rura 905 Twining Point Ct.,		
altimore	ages 1. int of He tr if Hem y or oth	20e. Method of Disposition 1 Description 20c 20c		City or Town, State One. Maruland
1	ortan Injury	21 Signa@word Furreral Service Licensee 22 Name and Address of Fecility		0 0C, 110 0g 000100
Ba	Dep Pen	brushna L. Jawel Schimunek Funeral to 9705 Belair Rd., Bo	Home, Inc. altimore, MD	21236
4	-	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec o shock, or heart feilure. List only one cause on each line.	r respiratory arrest,	Approximate Interval Between Onset and Death
	Physician			Onset and Death
	/Medical Examiner	Immediate Cause (Finel disease or condition resulting in deeth) a. Intestinal obstruction		18 MOOLO
п	5	Due to (or es e consequenca of):		
oil.	E	PARKINSON'S DISEASE		
3/7	be executed tolen and burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
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587	ng physicies the bu	resulting in death) Last Due to (or es a consequence of):		
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Records,	v requires that the death cerbeen signed by the ettendin should be deteched for use leted by Physician/N		24a. Was an eutopsy	24b. Were autopsy findings
Ö	The law require page 2 should Completed		performed?	available prior to completion of cause of deeth?
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a	icate h		1 Yas 2 No	1 Yas 2 No
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o	this eldi	1 Inpatient 2 EH/Outpetient 3 DOA 4 Nursing Hor	me 5 🕅 Residenca 6 □Oth 28d. Describe how injury occur	
5	After fune	1 ☑ Neturel 5 ☐ Pending (Month, Dey Year) Injury Work?		
S	Attending or death. octor: Afte by the fune	3 Suicide 6 Could not be 28e Place of Injury - At home form street factory office	28f. Location (Street end Numl	ber or Rurel Route Number,
Division	tel or Attending P rs after death. all Director: After t led in by the funers Certification:	4 ☐ Homicide building, etc. (Specify)	City or Town, Stete)	
	pours fille	29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	end due to the cause(s) and m	enner es stated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: 7	(Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred and menner stated.		
	outh outh	29b. Signatura and title of carifier 29c. Licanse number	29d. Date signe	ed (Month, Dey, Year)
	F 5 F 0	1 2010 11/18 MD 1026621	Sept.	8, 2000
	1	30 Name and address of person who completed cause of death (from 22a) (Time Brint)	1	10
	5	30. Name and address of person who completed cause of death (Itam 23a) (Type, Point)	tudobor) UK:
	State Registrar	31. Date filed (Month, Dey, Year) SEP 8 2000 September 1997 SEP 8 2000		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: 14 PER F.H. G792 State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Time of Death Day Month **Physician** December 28, 2000 Jose Isai Hernandez 5:12 PM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Clatanoff Pavilion Anne Arundel Annapolis 7. Age (In yrs. last birthdey) If Under 1 Year Months Days If Undar 24 Hrs. Hours Min. Birthplece (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Maryland Director none December 27, 2000 Usuai Rasidence of Decedent 10d. Inside City Limits 10a Stele 10b County 10c. City, Town or Location Maryland Anne Arundel 1 Yes 2 No Annapolis Director ed other than "natural", or items 23s or 28s-f event, the Medical Examiner must be notified 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 225-A Farragut Ct. Apt. 203 21403 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ∑ No If Yes, Give Yaar or Datas: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - American Indian 11. Marital Status Bleck, White, etc. WHITE 1€ Never Married 2 Married Wayes 2□No Specify:El Salvadoran Specify: - Hispanie by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) should be filed within Elementery/Secondary (0-12) College (1-4or 5+) Hygiene none none none 18. Mother's Neme (First, Middle, Maiden Sumema) 17. Fathar's Name (First, Middle, Last) and Mental is marked Jose Hernandez Dora Del Carmen 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Pages 1 and 2 s ment of Health an ant: If Nem 27 is: Jose Hernandez/father 225-A Farragut Ct. Apt. 203 Annapolis, MD 21403 Baltimore, 20b. Plece of Disposition (Name of cametery, cremetory or other pleca) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Ramoval from State Hillcrest Memorial Gardens 12/30/00 Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility
John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer tailure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner ed by the attending physician and detached for use as the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in deeth) Last Dua to (or as a consequence of): Box 68760 Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yee 2 No 3 Probably 4 Unknown Genetic Syndrome þ 24b. Were eutopsy findings available prior to 24a. Was en eutopsy performed? Completed peen completion of cause of death? The law has page 2 2 No 1 ☐ Yes 2 ☐ No After this certificate Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No P funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred Hospital or Attanding Pi
 24 hours after death.
 Funeral Director: After the total filled in by the funeral Certification: 28c. Injury at Work? 5 Pending investigation 1 25 Naturai 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a To the Funeral E completaly filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and little of cartifier M.D. 30 Name and address of person who completed cause of deeth (Item 23a) (Type, Print) dical Parkway Khast 25 003 9 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

ORIGINAL

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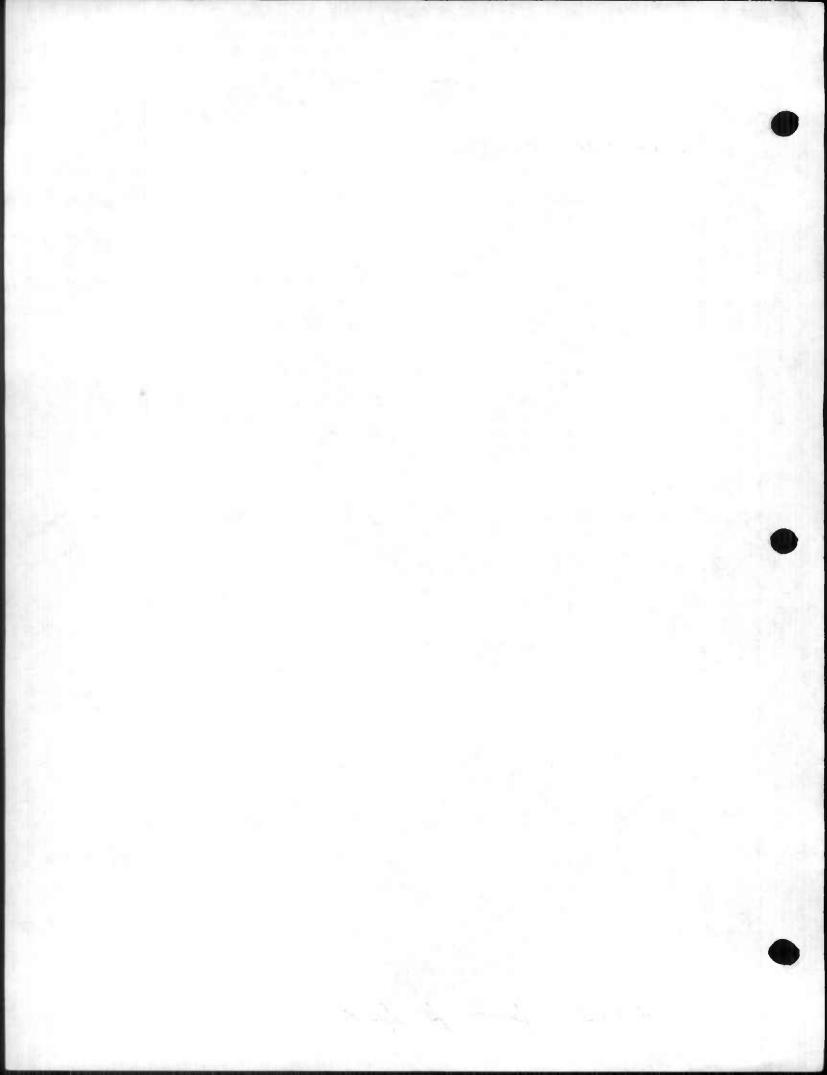
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State of Maryland / Department of Health and Mental Hygiene 0 4 3 5 8 1

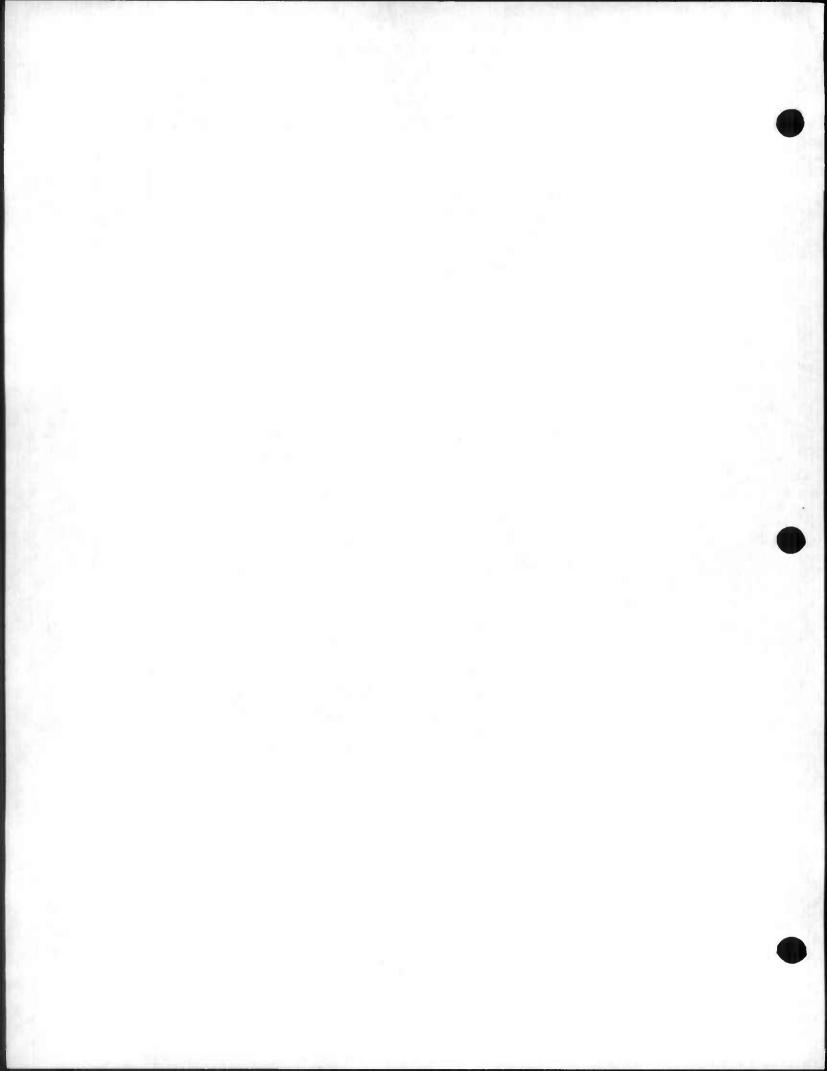
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al la				If Under 1 Year	If Undar 24 Hrs		th Year)	9. Birthpla	ce (Stete or Fore					
or	214-07-6510	1⊠M 2□F 83	Yrs.	Months Deys	Hours Min.	JUNE 1		Country MARYI						
	Usual Residence of Decedent													
	10a. Stata 10b. County	10c.	City, Town or Loca	ition				100	d. Inside City Limi					
5	MARYLAND ALLEG	ANY	CUMBERLA	AND					1 X Yes 2 □ N					
Director	10e. Street and Number			10f. Zip Code		12	10g. Citizen of W	hat Country	y?					
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Funeral	11. Marital Status	12. Was Decedenf Evar is	n U,S. 13. We	es Decedent of H	ispanic Origin? (S	specify Yas or No)- 14. Race	- American						
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b	3 Widowed 4 □ Divorced	Year or Detes: 941	-1945	Yes 2√ No	Specify:		Specify	WHJ	LTE					
Completed	15. Decedent's	Education	16e. Deceder	nt's Usuel Occup	ation	atorii -	16b. Kind of Bu	siness/Indu	stry					
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BeC	17. Father's Neme (First, Middle, La	st)			18. Mother's Ne	me (First, Middle	, Maiden Sumem	е)						
0	WILLIAM KASTNER				LORET	TA AMAN								
	19a. Informent's Neme/Reletionship	(Type, Print)	19b. Mailing	Address (Street	and Number or Ri	ural Route Numb	er, City or Town,	Stete, Zip C	Code)					
	CAROL NANCE	DAUGHTER	304 SIT	TON DRI	VE WASK	OM TEXA	75692							
	20a. Method of Disposition	20	b. Pleca of Disposit			Data	20c. Location -	City or Tow	n, Stete					
	1 Buriel 2 Cramation 3		CRA CAD			NT 9 200	ודם משמ ו	TMTCTO	ONE MD					
	4 Donetion 5 Other (Special Service Lie		OCKY GAP	VEI CEM		N 0 200	L KFD FL	TMISIC	ONE MD.					
The same	21. Salvice Ch	Time I	MI	ERRITT-A	DAMS FUN	ERAL HO	ME P.A.							
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Ine		b. Status 1	Post Tro	inshiata	al Esc	phage	tomy	12	5 days					
Examiner	Sequentially list conditions, if any, leading to immediate		o (or es e conseque											
	if any, leading to immediate	· Preumoni	ia					1 5	days					
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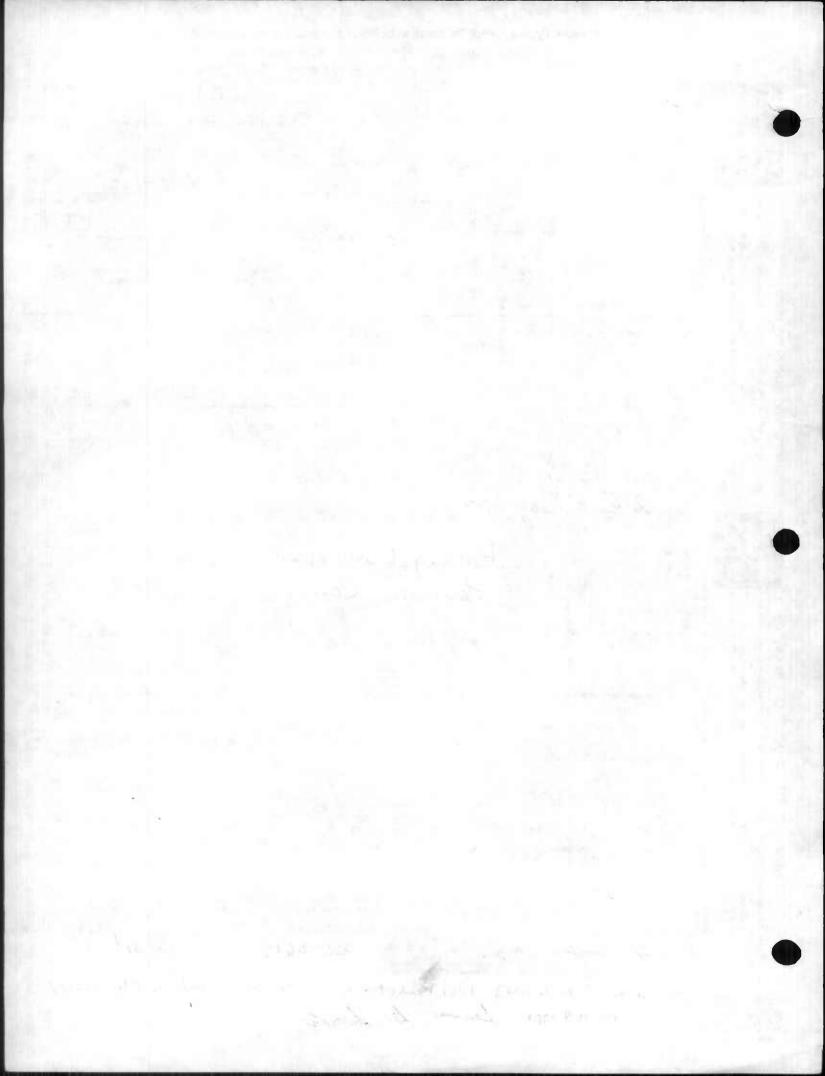
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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 4 3 5 8 3

	ADMEND	ITEM: #2/ PER	PHY G/94	4-21-06	ertificate	of L	Death		Re	eg. No.			
		1. Decedent's Name (First, Middle, Li						2	2. Date of Deat	th	V	3. Time of D	Seath
4	Physician (Madical	Aida	Marg	ulis					Month 12	30° 20	OO Yeer	7.40	7. 84
	/Medical Examiner	4a Facility Neme (If not institution, gi	ve street and number)		100	4	b. City, To	wn, or Loca	ation of Death	4c. County	of Death	7:40	AM
	Examinor	6185 Bellgrave	Court				Sali	sbury		Wicom	ico		
	Funeral			e (In yrs. last birthd	Months I	Yeer	If Under	24 Hrs. 8	B. Dale of Birth (Month, Dey, 12-6-2	Year)	9. Birthp	olaca (Stete or	Foreign
	Director	023-20-1914	1□ M 2□F	73 Yrs	Michael .	30,0	110010		12-6-2	27	N. Y	Ž.	
	p ,	Usuel Residence of Decedent 10e. Stete 10b. County		10c. City, Town or	Location							Od Inolda Cib	. I imite
show	show	Da allegh	env	Pittsbu							'	0d. Inside City 1 ☐ Yes	
	the Mer 28a-f at nounted												
	vith the Melon of 28a-f a	10e. Street and Number			10f. Zip C				1	0g. Citizen of 1	What Coun	ntry?	
	ifter death with the Meryland frems 23s or 28s-f show free results a needing at	3783 Churchvie				236			*****	U.S.A	e - Americ	an Indian	
		11. Meritel Stefus	12. Wes Decedent Armed Forces?		Was Deceder If Yes, specify	Cube	n, Mexican	n, Puerto R	ican, etc.)		ck, White,		
20	· · · >	1 Never Merried 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Detes:	NO	1 ☐ Yes 20	No	Specify:			Specify	v: Wh	nite	
Maryland 21215-0020	72 houn natural, dical Es			16a De	cedent's Usuel (Decuni	ation			16b. Kind of B	usiness/Inc	dustry	
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lar	should be nd Mental marked c	Samuel Marguli	s				S	ophie	Ka	atz			
ary	d 2 should be filed the end Mental Hyg 7 is marked othe traumatic event,	19e. Informent's Neme/Raletionship		19b. M	eiling Address (Street		-		, City or Town,	Stata, Zip	Code)	
	C = N L	Sharon K. Ferger	/Daughter	6	185 Be	l la:	rave	Court	Salis	sbury,	MD 21	.801	
re,	of Haali of Haali fitem 2	20a. Method of Disposition		20b. Pleca of Di		of				20c. Location			
Baltimore,	Pages nent of int: If its iry or o	1 ☑ Buriel 2 ☐ Cramefion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special		New Mon				ry	1/02/01	Long	Isla	and.	NY
alti	그 두 두 루	21. Signature of Funerel Service Lice	^	11011	22. Name end			_	1/02/01	L Bong	1010	211017	
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		23a. Pert1. Enter the diseese, or con	nplications that cause	d the death. Do not					respiretory arm		soury	Approximete	
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Ų	/Medical	Immediate Ceuse (Finel disease or condition	I	2-1-6	OLCA	_	+	3-11					
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68760,	certificate be executed in a physician and use as the burial-transmission.	Cause (Disaese or injury that initieted events resulting in death) Last Due fo (or as e consequence of):									1		
99	ing ph e as th	resulting in death) cast											
Box	attendir for use	d.											
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brd	been sign should be	RESIDENCE OF THE PARTY OF THE P							24a. Wes e	n autopsy med?	av	era autopsy fir eilable prior to)
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>	Z 0 0	1 Yes 2 No	Hospitel: 1 Inpatie	ent 2 ER/Outpa	tient 3 DOA	Oth	er: 4 Nu	ursing Hom	e 5 Raside	ence 6 Dott	ner (Specif	y) Daught	er
Division of	After th funeral funeral	27. Manner of Deeth 1-2 Naturel 5 □ Pending	28a. Date of Inju (Month, De	iry 28b. Tim	e of 280	. Injun	y at k?	28	8d. Describe ho	ow injury occu	red		
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<u>></u>	ar de rect rect by t	3 Suicide 6 Could not I determined	28e. Piece of in	jury - At home, ferm, c. (Specify)	street, fectory,	office		28	Bf. Location (Si City or Town	treet end Num. n, Stata)	ber or Rure	el Routa Numb) <i>01</i> ,
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	Dom?	30. Name and address of person who	complated ceusa of	daeth (Item 23a) (Ty			_		-				
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	State	31. Dete filed (Month, Dey, Year)	32. Regist	ar's Signeture	4 1	,	,				154		
	Registrar	100 0 3	7001	- MEN	J. A.	200	1/2/						



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. ADMEND ITEM: #27 PER PHY G793 3-20-01 WR. Continued of Death Certificate of Death 2. Date of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Deeth Day **Physician** Helen Hudson Montague December 28, 2000 12:30 p.m /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Examiner Magnolia Hall Nursing Home Chestertown If Undar 24 Hrs. 8. Date of Birth (Month, Day, August 9, 5. Social Security Number If Undar 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□M 2\ F Days 82 Yrs. 220-01-5774 Henderson, Maryland Director Usual Residence of Decedent the Maryland 10a State 10b. Countr 10c. City, Town or Location 10d. inside City Limits 28a-f show 1 XYes 2 No Directo Maryland Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Nerna 23a or troumatic event, the Medical Examiner must be 200 Morgnec Road 21620 USA Funeral filed within 72 hours after deeth 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 natural, or 1 ☐ Yes 2 ◯XNo Specify: White p 3 Divorced 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 16h Kind of Business/Industry than Elementery/Secondary (0-12) College (1-4or 5+) Teachers Aid Education le marked other 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surnema) . Peges 1 end 2 should be fil ment of Health and Mental H lant: If item 27 is marked off Harry Hugh Hudson Carrie Melvin 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 221 Richard Drive, Chestertown, Maryland 21620
a of Disposition (Name of Date 20c. Location - City or Town, State Beatrice Scull 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Depertment of Important: If It eny injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sudlersville Cemetery 12/30/2000 Sudlersville, MD 22. Name and Addrass of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 23a. Part1. Entar tha disease, or complications that caused tha death. Do not enfer tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsal and Daath Physician Immediate Cause (Final disease or condition resulting In deeth) /Medical 100175 Prianain Examiner Due to (or es e consequence ot) Physician/Medical Examiner 57179 Demon DA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequenca of): been signed by the attending physician and should be detached for use as the burial-trai The law requires that the death certificate be execu that initiated events resulting in deeth) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this Certification: 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Attending 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide

Division of Vital Records. P.O. Box 68760 ours after death. To the Hospital within 24 hours a To the Funeral D

> State Registrar

edical

4

29e. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month Day Yey") 2000

John C. Seymour, 122 Speer Road, Suite 5, Chestertown, Maryland 21620 Aggistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end manner es steled.

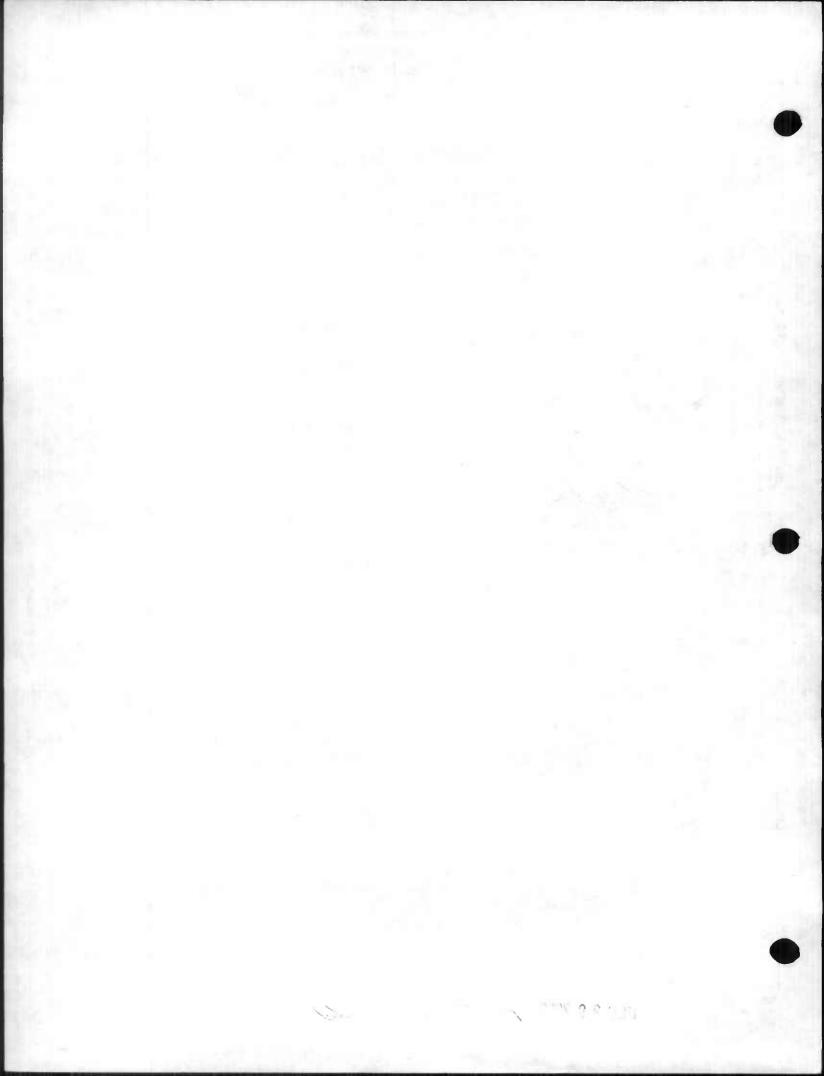
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licansa number

12-0013824

29d. Data signad (Month, Day, Year)

12-19.00



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and	Mental Hygiene
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amend item 18 per fh G792 2/2/01 yf Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** Jeannette R. Meade 21,2000 7:00 PM December /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 710 Springdale Avenue Annapolis Anne Arundel If Under 1 Year Birthplece (Stete or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) **Funeral** Days Hours Min. 10 M 20 F Yrs 78 Director 220-16-8398 Oct. 10,1922 Maryland Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 710 Springdale Avenue 21403 United States Funeral death Herns ? 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. ges 1 and 2 should be filled within 72 hours after it of Health and Mental Hygiene.
If them 27 is marked other than "natural", or itse 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 Married timore, Maryland 21215-0020 1 Yes 2 No Specify: specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Arthur C. Hall Jessie Hall Jessie Howard 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Richard A. Meade (husband) 710 Springdale Ave. Annapolis, Maryland 21403 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e Method of Disposition Date 1X Buriel 2 ☐ Cremetion 3 ☐ Removel from State ğ 4 ☐ Donetion 5 ☐ Other (Specify) Hillcrest Memorial Gardens12/27/2000 Annapolis, MD 22. Name and Address of Fecility John M. Taylor Funeral Home, Inc. 21 Gionature of Funeral Servica Licansee 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between **Physician** Waldenström's macroglobulinemia immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or as e consequence of): Physician/Medical Examin The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initialed events resulting in death) Lest Due to (or es a consequenca of): P.O. Box 6876 the Due to (or as a consequenca of) Po Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown of Vitai Records, þ 8 24b. Were eutopsy findings available prior to completion of cause of death? page 2 should Be Completed 24e. Wes en eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No this certificate or Attanding Physician; 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural after death. 1 Yes 2 No 2 Accident the 6 Could not be 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral E 29e. Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, dete and plece, end due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, dete and plece, end due to the ceuse(s) 29b. Signature and title of certifier Schoulls US 29d. Date signed (Month, Day, Year) 29c. License number 22/2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Bestrate Annapolis Md. 21401 elonich, mo. 32. Registrer's Signeture 31. Dete filed (Month, Dev. Year) State Registrar 26 2000

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene U Certificate of Death Amended Item#1 perHHDG792 2/1/2001 EW 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dennis Jefferies Milburn Month 2016 DENNIS JUNE MILBURN 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND HOSPITAL BALTIMORE If Under 24 Hrs. 8. Date of B Baltimore 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Days 1 € M 2 □ F 212-62-0668 47 Nov. 24, 1952 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 PNo Maryland St. Mary's Leonardtown 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 23765 Hollywood Road 20650 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11 Marital Status 1 Yes 2 No
ff Yes, Give
Year or Dates: 1 Never Married 2 Married Specify: 3 Widowed 4 Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Cottege (1-4or 5+) 10 Car Detailing Car Detailer 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Joseph Fred Milburn Lillian Lucille Dorsey 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Lillian Beander / Sister 22500 Wainwright Court, California, Maryland 20619 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gardens 7-5-00 Leonardtown, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Mula Du Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings 24a. Was an autopsy performed? available prior to completion of cause of deeth? 1 Yes 2 No 1 Yes 2 No 25. Was cese referred to medical examiner? 26. Piece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 5 Pending investigation

Examiner or Attending Physician:

of Vital Records, page 2 Division after death. yd ui 24 hours Hospital

Physician

/Medical

Examiner

Funeral

Director

or items 23a or 28a-f show

"natural".

Hygiene.

. Pages 1 and 2 should be fill trainent of Health and Mental H tent: If Itam 27 is marked out

other

Department of Health as important: if Itam 27 is any injury or other trait once.

Physician /Medical

filed within 72 hours after

21215-0020

Maryland

Baltimore.

the Medical Examiner must be notified at

Directo

Funeral

2

Completed

Completed by Be Medical Certification: To

Physician/Medical

27. Menner of Death Natural 2 Accident 3 Sulcide

4 Homicide 29a. Certifier

6 Could not be determined

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

2 No 1 Yes

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

Certifying Phyeiclan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Res. 000

29c. License number

29d. Date signed (Month, Dey, Year) 27 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

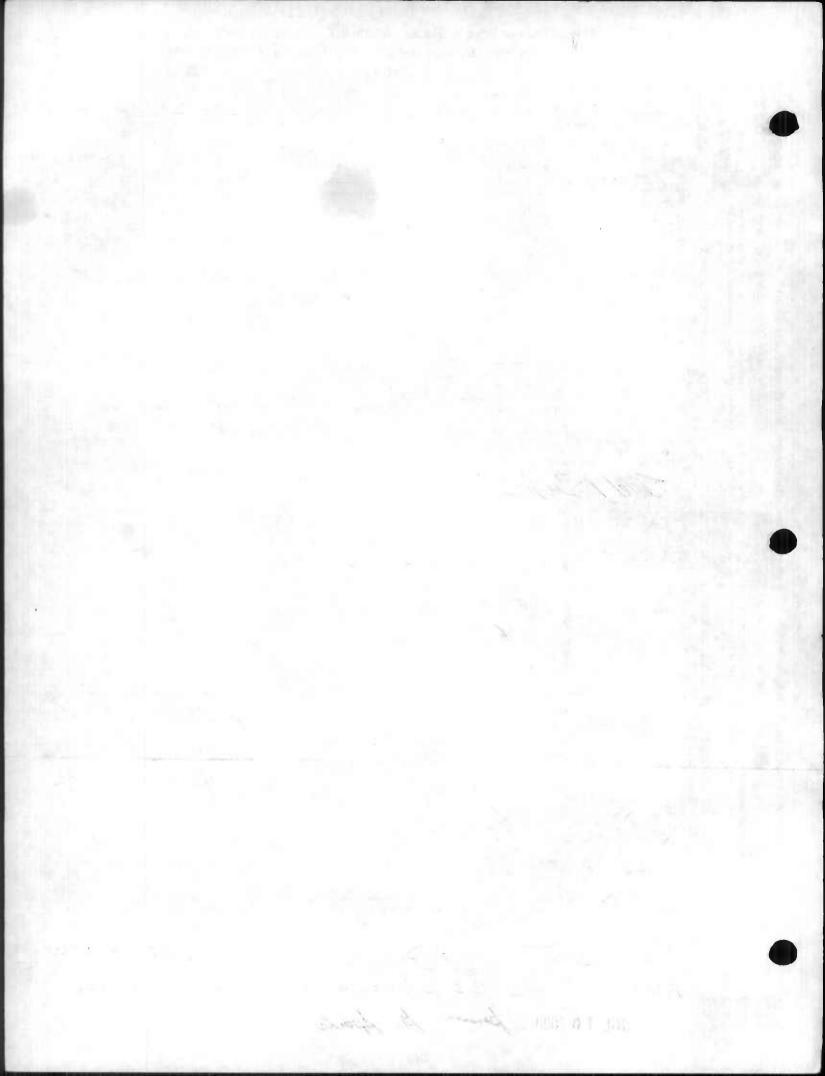
S. GREENE St. BACTIMORE, MD 21201 22 31. Date filed (Month, Day, Year)

Registrar

JUL 1 0 2000

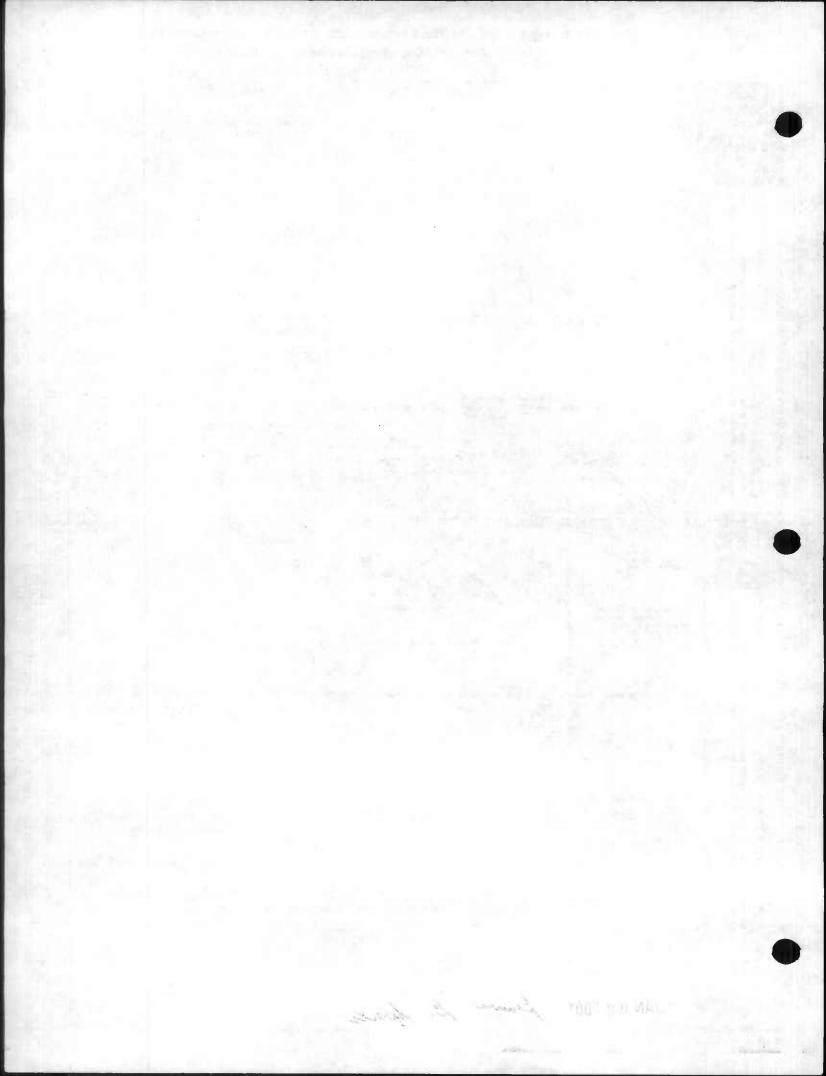
32. Registrar's Signature

To the within 2 To the



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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SORENSEN VINCENT GARY 30 2000 NOON 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WORCESTER CROPPER ISLE RD. BERLIN 8. Date of Birth Month, Day, Yea 11-6-5 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 D C 5. Social Security Number 7. Age (In yrs. last birthday) Days Months Hours 215-58-7686 DEM 20 F 50 Yrs. DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. BERLIN 1 ☐ Yes 2 No WORCESTER 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 9346 CROPPERISLE RD. 21811 U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give WHITE 1 Yes 2 No Specify. Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PLUMBING STEAMFITTER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) VINCENT A. SORENSEN MARGARET O'HARA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12140 LONGRIDGE LANE BOWIE, MD. 20715 MARGARET E. SORENSEN 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) SALISBURY CREMATORY 1-1-01 SALISBURY, MD. 21. Signature di Funi 22. Name and Address of Facility ULLRICH FUNERAL HOME BERLIN, MD. 21811 23a. Parti-Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a / Din M alishelic disease or condition resulting in death) atry Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner

that the death certificate be executed

The law requires

Hospital

To the To the To the

P.O. Box 68760.

Records.

Division of Vital or Attending Physician: **Physician**

/Medical

Examiner

Funeral

Director

rai", or items 23a or 28a-f show Examiner must be notified at

death

permit. Pages 1 and 2 should be filed within 72 hours after dea.
Department of Health and Mental Hygiene.
Important: if frem 27 is marked other than eny Injury or other traumer.

ES

Director

Funeral

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Completed

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Examiner

physician and the burial-transit attending pl signed by the a page 2 certificata funeral director. Certification: To shis After 24 hours after death.

Funerel Director: A 3

Physician/Medical Be Completed by

25. Was case referred to medical 1 Yas 2 No 27. Manner of Death

1 Natural 2 Accidant 3 Suicida

4 Homicide

(Check onh

29b. Signature and title of pertifie

29a, Certifian

Andrea

5 Pending invastigation

Hoffman

6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State) Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

Berlin

29c. License number 1536/2 and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

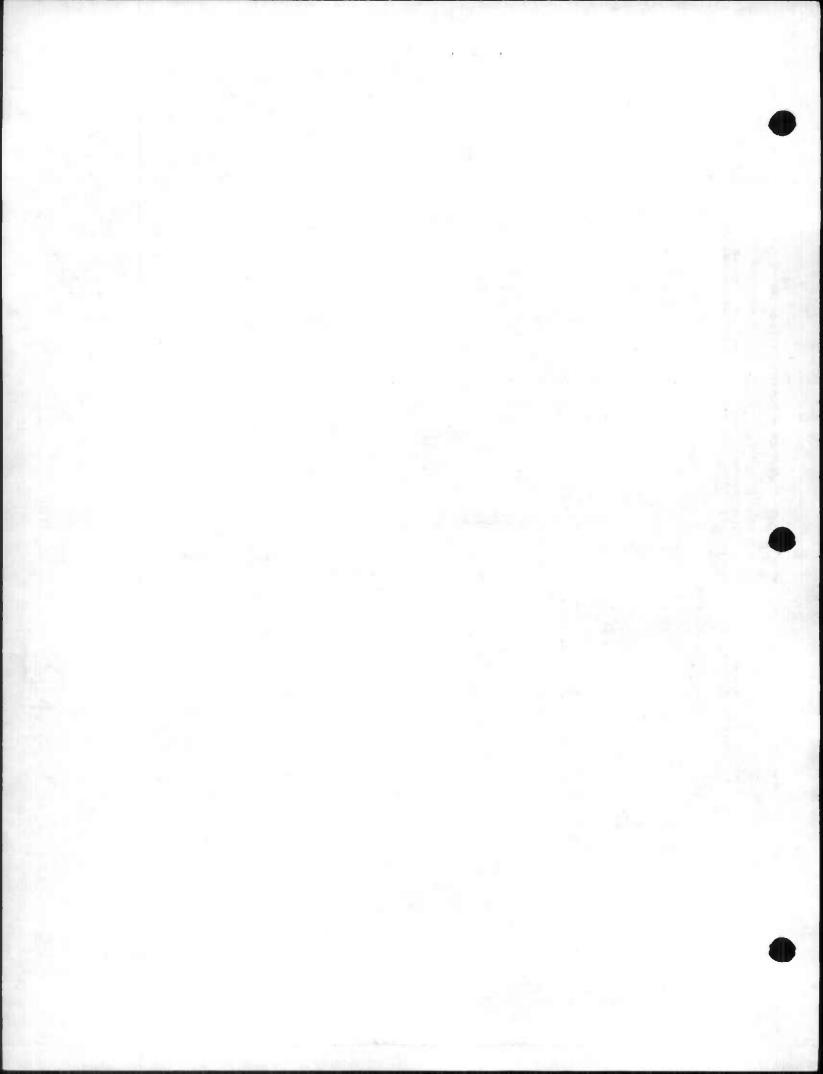
Registrar

filled in

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aier WD 32 Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AMEND# 28 a, b, c 12/29/00 cmatate of Maryland / Department of Health and Mental Hygien Certificate of Death Per Phy. AACO Health Dept 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Time of Death Month Yeer **Physician** John Kevin Trader, Sr. 5:58 Am 9.9 3000 /Medical 4a Facility Nama (If not institution, give street end number, 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Hnne Hrunde urhie HOSPItal Arundel 5. Social Security Number If Undar 1 Yeer 6. Sex 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** 1 € M 2 □ F Months Days Hours Min 44 Yrs 220-66-7230 Director 4, 1956 Maryland Usual Residence of Decedent 10a Stete 10c. City. Town or Location 10b. County 10d. toside City Limits Anne Arundel Millersville 1 Yas 20 No Director 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with thygiene.
Hygiene, then treature?, or Items 23e or item; the Medical Examiner must be n 261 Poplar Road 21108 USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indien. 11. Meritel Stetus Black, Whita, atc. 1 ☐ Yes 2 ☑ No It Yes, Give Year or Detes: 1 ☐ Nevar Married 2 ☑ Married 1 Yes 2√ No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Etementery/Secondary (0-12) College (1-4or 5+) 12 Fireman Public Safety 17. Father's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be is marked John F. Trader Patricia Elliott 2 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melting Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Pages 1 and 2 Lou Ann Trader/Wife 261 Poplar Road Millersville, MD 21108 rtant: If Item 27 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Dec. 29 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Ramovel trom State 2000 Glen Burnie, MD 4 ☐ Donetion 5 ☐ Other (Specify) Glen Haven Cemetery 21. Signature of Euperal Service Con-22. Neme end Address of Fecility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Deetl **Physician** /Medical tmmediete Cause (Finel ON CHITIS ONE WEEK disease or condition resulting in deeth) Examiner ESPIRITORY Examiner Sequentielly list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or trijury that initieted events resulting in death) Last physician s the burial Box 68760, 8 Physician/Medical Dua to (or as a consequence of) death certificate attending p detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ Division of Vital Records, 24b. Were eutopsy findings available prior to completion of cause ot deeth? 24a. Wes an autopsy performed? Completed TRIAL SEPTIL hes REPUR HOW 1 Yes 2 No 1 Yes 2 No certificate Attanding Physician: funeral director, 25. Wes case reterred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1□ Yes 2☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. tnjury et Work? Certification: After 1 Neturel 5 Pending 1 Yes -2 death. 2 Accident investigetion aftar death Director: 6 Could not be determined 3 Suicide To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, tectory, office building, etc. (Specify) 4 Homicide 29a. Certifier edical 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signetura and titla of certifiar 29d, Dete signed (Month, Dev. Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 80 1DMIPL COOLPINE 31. Dete tiled (Month, Day, Year) 32. Registrer's Signeture State DEC 29 2000 Registrar

DHMH 16 Rev 6/95

PRU-DS

ORIGINAL

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 43590 ADMEND ITEM: #19B PER F.H. G793 3-12-01 WR. Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Francis Sylvester Yates. 3:15 AM December 28. 2000 /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 5912 Cable Avenue Camp Springs Prince Georges | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 8, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2 F 69 217-28-8295 1931 Maryland Director Usual Residence of Decedent the Maryland 10a Stete 10h County 10c. City. Town or Location 10d. Inside City Limits of other than "natural", or flams 23s or 28s-f show event, the Medical Examiner must be notified all 1 ☐ Yes 2 ☑ No Directo Maryland Prince Georges Camp Springs 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 5912 Cable 20746 USA Avenue death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Maritai Status Baltimore, Maryland 21215-0036

odnit. Pages 1 and 2 should be filed within 72 hours after of pearment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or heapy injury or other traumatic event, the Medical Examinations. 72 hours after 1 Never Married 2 Married Specify: White 1 ☐ Yas 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Glazier Glass Making/Repair 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lillian E. George C. Herbert Yates 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5912 CABLE AVE, CAMP SPRINGS, MARYLAND 20746 19a. Informant's Neme/Relationship (Type, Print) Sara E. Yates/Wife same as item 20b. Pleca of Disposition (Name of cametery, crematory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, State Dete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/2/2001 Clinton, MD Resurrection Cemetery 21. Signature of uneral Service Libensee / 22. Name and Addrass of Facility George P. Kalas Funeral Home, P.A. 23a. Pelrf. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or haart failura. List only one cause on each line. alas Approximete Interval Between Onset and Death **Physician** en Dic CACDIO CARaly Gras /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Physician/Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): that initiated evants resulting in death) Last Due to (or as a consaquenca of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 10 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of deeth? 1 ☐ Yes 2 Ø No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 86 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Othar (Specify) 10 1 Yes 2 No this. 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth Certification: 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred 1XXX Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 6 edical 29e. Certifier XCertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. memon the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) and menner stated. (Check only one) å 29b. Signeture and title of continu 29d. Date signed (Month, Day, Year) 20

State Registrar 30. Nama and address of pure

3 Data filed (Month, Day, Year,

JAN 02 2001

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DHMH 16 Rev 6/95

J. Sparks

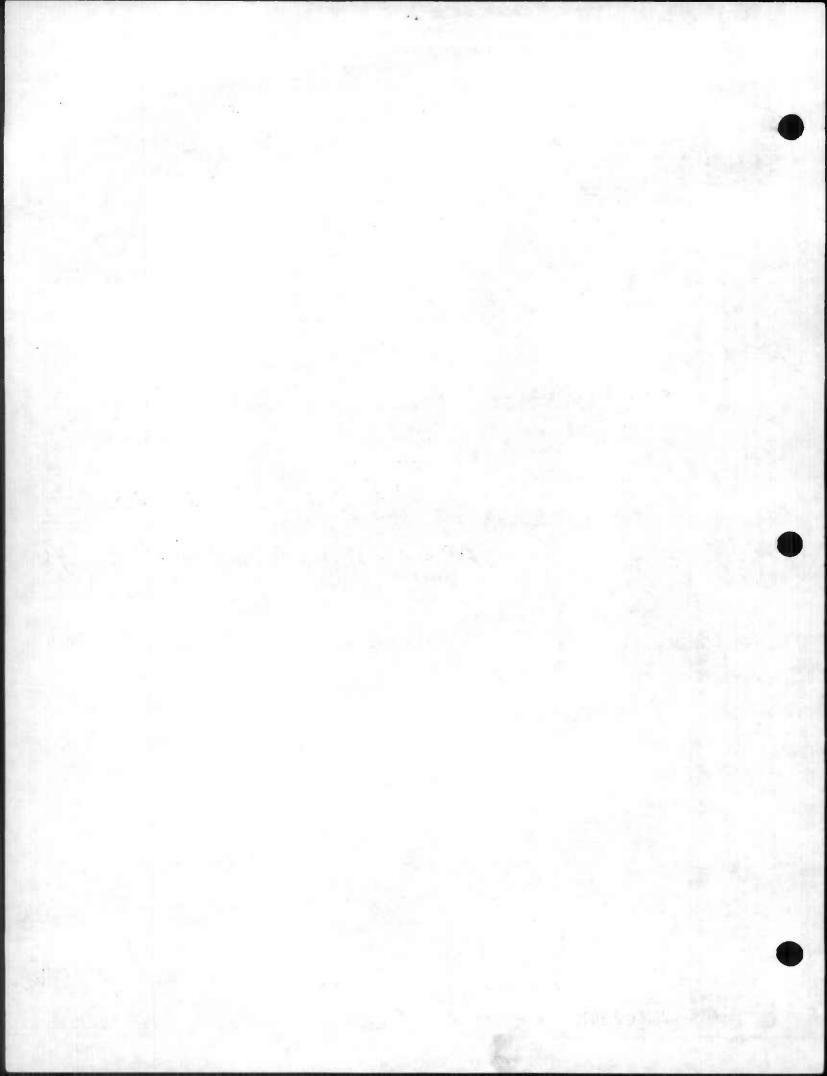
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completed cause of deeth (Item 23a) (Type, Print)

32. Registrar'a Signature

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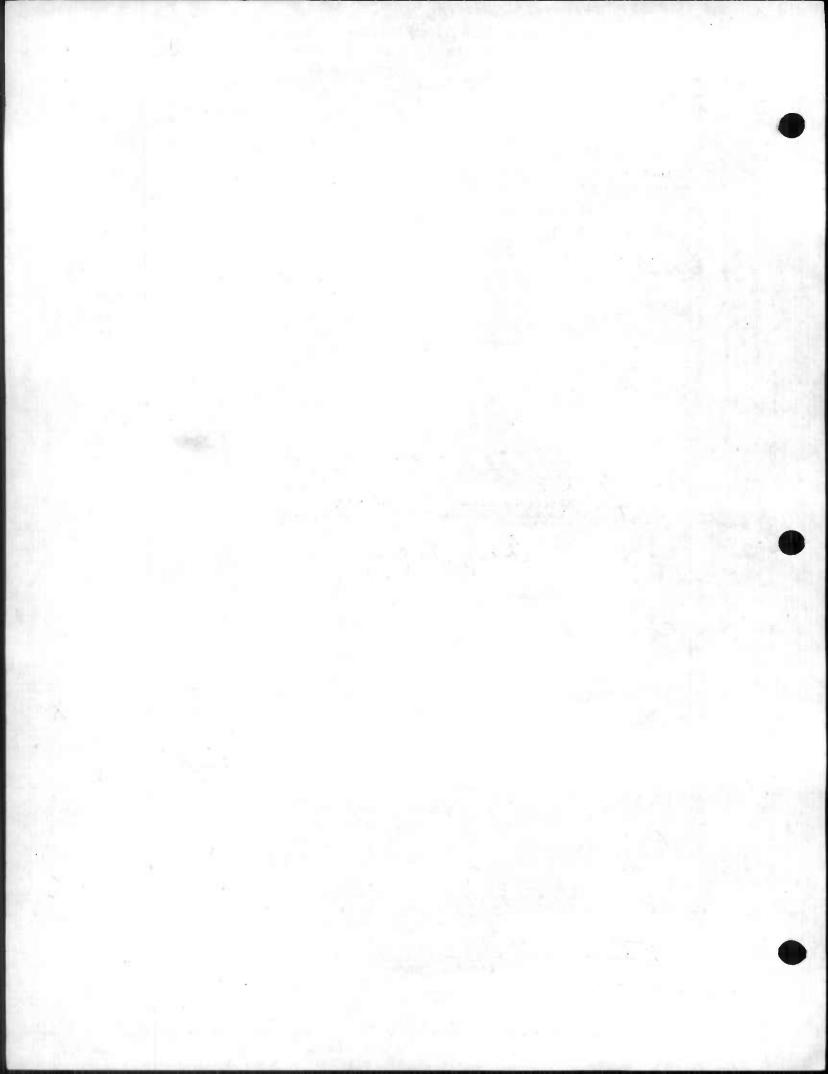


Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygied 3 5 9 1

					Cei	rtifica	te of	Death		F	Reg. No.		
	_	Decedent's Name (First, Middle, La	ist)		RITC.					2. Date of Dea	ith Day	Year	3. Time of Death
Physician /Medical	_	Clarence			Talbert	t				DECEM			0 1348
Examiner	40	Facility Name (If not institution, given	e street and num	ber)				4b. City, To	wn, or Lo	ocation of Deeth			0 1040
	P.	507 E. PATAPSCO	AVENUE					BALTI	MORI	F.		N/A	
Funeral		Social Security Number 6. 5	Sex	7. Age (In yrs.	last birthday)	If Unde	Deys	If Under	24 Hrs. Min.	8. Dete of Birth (Month, Day	Year)	9. Birth	plece (State or Foreign
Director		214-40-7932	10XM 2□ F	56	Yrs.					Sept. 2	, 1944	Mar	yland
2 ,		sual Residence of Decedent Da. State 10b. County		100 0	ib. Tour as La	ontion						1.	Od Incide City I limite
death with the Maryland rms 23s or 28s-f show rms to notified					ity, Town or Lo	Cation							
M Park				Dal	CIMOLE								
23s or 28s-f show	10	e. Street and Number	- A				p Code 21225					9. Birthplece (State or F Country) Maryland 10d. Inside City 10x Yes 2 of What Country? ed States Raca - American Indian, Black, White, atc. city: White Businass/Industry e of MD name) wm, State, Zip Code) 21225 on - City or Town, State tsville, MD Approximate interval Between	
23		509 East Pataps	_									9. Birthplece (State or F Country) Maryland 10d. Inside City to 1 (A Yes 2) If What Country? Id States aca - American Indian, lack, White, atc. Sity: White Businass/Industry of MD ame) In, State, Zip Code) 1225 In - City or Town, State CSVIILe, MD Approximate	
	11	. Marital Status	12. Was Deced	ces?	J,S. 13.	lf Yes, spe	ecify Cubi	an, Mexican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)			
9 9 9		1 Never Merried 2 Married 3 Widowed 4 Divorced	1 ☐ Yes If Yes, Give Year or Da	9		1 🗆 Yes	2 X No	Specify:			Specif	y: Wh	ite
"natural", pulcal Exit	-	15. Decedent's E		105.	16a. Dece	dent's He	ial Occur	nation			16h Kind of B	lueinase/In	dustry
. 2		(Specify only highest gra	ade completed)		(Give	kind of w	ork done	during most	t of work	ing	TOD. TANG OF E	rg sin les sin	dustry
marked other than marked other than marke avent, the M		Elamentary/Secondary (0-12)	College (1-	4or 5+)	Super				unds	3)	State	of M	D
Day of	17	. Father's Name (First, Middle, Last)		L					a (First, Middle,	Maiden Surnar	me)	
ed off		(Unknown)	Talbert					(Unkr	nown)			
it of results and Mental hygiene. If item 27 Is merked other than or other traumatic avent, the Merican To Be Compi		9a. Informant's Name/Ralationship			19h Mailir	no Addres	s (Street				r City or Town	State Zi	n Code)
Thand Traum		Michele Rogers /								altimore			
of Health ar Itam 27 Ia other trai		a. Method of Disposition		20b.	Place of Dispo	sition (Ne	me o/		1	Date			own, State
0 H H		1 Burial 2 XCremetion 3			cemetery, cres				Tnc	1/31/01	Bol+	ev: 11	e MD
Department of Important: If any Injury or once.	2	4 □ Donation 5 □ Other (Special Signature of Euperal Service Lice	nenn-	GI								SATIT	C, 11D
any to	-	* AAXX	11			CAFA	Step	phen D	. Lo	hrmann,	P.A.		
		" distribution	man			8717	Gree	en Pas	ture	es Dr.,	Towson	, MD	
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hysician	15	Court of the Law.	1		_								Oriset and Death
/Medical xaminer	di	nmediate Cause (Final isease or condition	. Como	hop	Tongo	ع						1	
		esulting in death)		Due to (or as a consac	quance of):						
an and nal-transit Examiner			b								138X3	1	
-tran	S	equentially list conditions,		Due to (or as a consec	quence of):						
attending physician and for use as the bunal-transit clan/Medical Examir	o C	equentially list conditions, any, leading to immediate euse. Enter Underlying ause (Disease or injury	C										
physicients the bu	th	eat initiated events esulting in death) Last		Due to (or as a conseq	uenca of)	:						1 225-4
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or us			u.	10.00	337								
d by the attendetected for un	P	art II. Other significant conditions	contributing to dea	ath but not re	sulting In the u	nderlying	cause giv	ven in Part f		23b. Dld 1	obacco uss co	ontributs I	to the cause of death?
etaci Phy										10	Yes 2 No	3 Pro	bably 4 Unknow
52 5	-								—			T	71
page 2 should											an autopsy med?	81	Vere autopsy findings
has be ge 2 sh	-						-			lim	tel		ompletion of cause death?
page Com										1	res 2 No	1	Yes 2□ No
certificate rector, pag		5. Was case referred to medical						26. Place	of Deat	h (Check only o	ne)		
0 D		examiner? 1- Yes 2 No	Hospitat: 1 🗆 In	patient 2	ER/Outpatier	nt 3 🗆 🖸	OA Oth	her: 4 Nu	ırsing Ho	ome 5 Resid	lance 6 DOt	har (Spec	ify) at scene
neral		. Mannar of Death	28a. Date o	f Injury	28b. Time o	1	28c. Inju	ry at		28d. Describe I	now injury occu	rred	
atio		1 Natural 5 Pending 2 Accident Investigation		,,,	,,	M		Yes 2	No				
by the		3 Suicide 6 Could not be determined	289. Place	of Injury - At h	nome, farm, str	reet, facto	ry, office			28f. Location (S City or Tox	Street and Num	ber or Rui	ral Route Number,
al Director: After the din by the funera Certification:			Dantaire	g, old. (Opoul	.,,,						,,		
within 24 hours are road. To the Funeral Director: After this completely filled in by the funeral Medical Certification:		9a. Certifier 1 Cartifying Pi (Check only one) 1 Medical Example	nysician: To the i miner: On the ba and mann	sis of examina	owledge, deatl ation and/or in	h occurred vastigatio	d at the ti	me, date an opini <i>on</i> , daa	d place, th occur	and due to tha red at the time,	cause(s) and m date and place	anner as	stated. to the cause(s)
within 2 To the comple		9b. Signeture end title of certifier	and marm	or stated.		25	9c. Licens	se number			29d. Dete sign	ed (Month	, Dey, Year)
¥ F 8			111	.7									
2	_	I headned	1. Kin	5 no			U.C	.M.E			DECEME	SER 2	9,2000
/	30). Name and addrass of person who	completed cause	of death (Ite									
Mr.	17	THE THORK MICIN				I Pe	nn S	treet	, Ba	ltimore	, Maryl	and 2	21201
State	31	1. Date filed (Month Day Year) 7	01 32. 5	egistrar's Sign	ature	1	ne V	11					

DHMH 16 Rev 6/95

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					Cert	ificate of	Dealli	1	Reg. No.		
an	1. Decedent's Name							2. Date of D Month	eeth Dey	Year	3. Time of Deat
al	ELMER HO	ORTON DUI	FF					DE	C 30 200	0	5:53
er	4a Facility Name (It	f not institution, giv	re street end number)			4b. City, Town, or	Location of Dea	th 4c. County	of Death	
	NATIONAL	L NAVAL N	MEDICAL CE				BETHESD		MONT	GOME	
	5. Social Security N	umber 6. 5	Sex 7. A	ge (In yrs. le		If Under 1 Yeer Months Days		8. Date of B	irth Pey, Year) 28, 1921	9. Birthp	place (Stete or For
	278-18-0	203	M 2□F	79	Yrs.			January	28, 1921	Ohi	LŐ
	Usual Residence of			10.00	T	At a m					ad to the Oh . I h
	10a. State	10b. County		10c. City,	Town or Loca	ation				1	Od. Inside City Lir
-	Maryland	St. Mar	y's	Le	exingto	n Park					1 Yes 2X
חוברוס	10e. Street and Nur	mber				10f. Zip Code			10g. Citizen of V	Whet Coun	ntry?
- Allera F	23359 Gre	een Holly	Road			2065	3		U.S.A.		
	11. Maritel Status		12. Was Decedent	Ever in U,S	i. 13. W	as Decedent of	Hispenic Origin? (S	Specify Yes or N	0- 14. Rac	e - Americ	
	1 Never Marri	ed 2 Married	Armed Forces				oan, Mexican, Puer	to Hican, etc.)		ck, White,	etc.
	3 Widowed	4 Divorced	If Yes, Give Year or Dates:		11	Yes ZX No	Specify:		Specify	" Wh	ite
		15. Decedent's E	ducation		16a. Decede	nt's Usuel Occu	petion		16b. Kind of Bu	usiness/Inc	dustry
		ify only highest gre		(F.)	(Give ki	ind of work done O NOT use retire	duning most of wo	rking			
	Elementery/Second 12th	ndary (0-12)	College (1-4or	3+)	Medica	al Corps	sman		U.S. N	Javy	
	17. Fether's Name ((First, Middle, Last)			1	1	me (First, Middle	e, Meiden Sumem	-	
		George Di					Inez N	Vancy Ba	nning		
	19a. Informant's Na				10h Mailing	Addrage /Stree	at end Number or R			State 7in	Code)
				-)							
	Patricia 20a. Method of Disp		(Daughter		1903		Avenue,	W111OW	20c. Location -		
i			Removal from State	000	metery, creme	etory or other pla	ace)	Date	200. Eocation -	City of 10	JWII, State
		5 ☐ Other (Specif			aculate :	Heart of	Mary Cemet	ery 1/3/0	Lexingto	on Par	k, Maryla
	21. Signatule of Fu	neral Service Lice	130y 0. n.		22 M:	Name and Addr	ess of Facility Ey-Gardin	er Fine	ral Home	. P.7	Α.
ı	Mic	Mac Vox	Hudi	100-1			270, Lec				
	23a. Part1. Inter th	he disease, or com	plications that cause	ed the death.						dila .	Approximate
	shock, or hear	rt failure. List only	one cause on each		DO HOL OHIO	110 111000 01 09	ing, such as cardia				
1				line.	DO NOT OTHER	ino modo or dy	ing, such as cardia				
	Immediate Ceuse (Final		line.	DO NOT GINE	and mode or dy	ing, such as cardia			1	
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	disease or condition			ENIC_SH			ing, such as cardia				
	disease or condition resulting in death)	n e		ENIC SI Due to (or a	HOCK as a consequ	ence of):	ing, such as cardia				
	disease or condition resulting in death)	n e		ENIC SI Due to (or a	HOCK	ence of):	ing, such as cardia				
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No server inforces

			Cei	niticate	of Deat	n	R	eg. No.		
1. Decedent's Name (First, Mid	idle, Last)	THE CAN	1 1 1 1 1						Vara	3. Tima of Death
Bertha Marie	e Duff						DECEMBE	ER 31, 2	2000	9:30AM
		t and number)			4b. City					
										.10
	-			416223				1		
5. Social Security Number	6. Sax	2016				er 24 Hrs.	8. Date of Birth (Month, Day	Year)	9. Birthpi Coun	lace (Stete or Foreign try)_
160-03-1249	I I M	2X"	81 Yrs.				January	26, 1919	Penns	sylvania
Usual Residence of Decedent										
10a. State 10b. Coun	ity	10c.	City, Town or Lo	ocation					10	0d. Inside City Limits
Maryland St	Mary's	T	exinato	n Park						1 ☐ Yes 2 No
	1			1	ode		1	Og. Citizen of V	Vhat Coun	trv?
	11. 5	- 3								
						011010	.W. M			an Indian
11. Marital Status	12. W	Vas Decedent Ever in irmed Forcas?	1 U,S. 13.	Was Daceden If Yes, specify	of Hispanic (Cuban, Mexic	Origin? (Spec can, Puarto F	city Yes or No- Rican, etc.)			
	arried 1	XYes 2 No								
3 XWidowed 4 □ Divorce	ed Y	ear or Dates:		103 25	V.to Shace	.,		Specify	Whi	Lte
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	, ,	ollege (1-4or 5+)	Home	maker				Own H	iome	
	la Last)				18 Ma	ther's Name	(First Middle	Meiden Sumam	Θ)	
									-/	
John J. Shaft	rer		A SEC		1					
19a. Informant's Name/Relation	nship (Type, P	Print)								
Patricia Gaid:	ish (Da	ughter)	1903	Flemi	ng Aver	nue, W	illow G	rove, Per	nsylv	ania 19090
20e. Method of Disposition			D. Place of Dispo	sition (Neme	of					
		val from State				lana da aba	1/2/01	Torrison	a ThereI	Man I and
		l Ir					1/3/01	rexingto	1 ralk	, rarylaru
21. Signature of Funeral Service	te Licensee	0	∩ M	2. Nama and /	Address of Fai	cdiner	Funera	1 Home.	P.A	
menhad	Neur	Varia								
23a. Part 1. Enter the disease,	of complicatio	ns that caused the	outh. Do not en	er the mode	of dying, such	as cardiec or	r respiretory arr	rest,	21	Approximete
snock, or heart feilure. Li	ist only one ce	use on each line.							- 1	Onset and Death
Immediate Cause (Final		1		. 1	11-	_				Ha.10
disaase or condition	Θ	KESPE	KATON	7 ETV	uns	.7 .				HOUR.
		Due t	o (or as a conse	quence of):						11
		COPD	EXA	CENT	SATION	J.			1	1towns
Sequantially list conditions	0	Dua I	o (or as a consec	quence of):						
if any, leading to immediate										THUS
Ceuse (Diseese or injury	C				٥,					17/1-12
resulting in death) Last		Dua le	o (or as a consec	(uanca of):						
	d						(COV 1)			
	- d.						EQUIP			
Part II. Other algnificant condi	itiona contribut	ting to death but not	resulting in the u	nderlying cau	se given in Pa	irt I.	23b. Dld to	obacco uae co	ntributa to	the cause of death
				19 19 1			101	(ea 2□ No	3 Prol	bebly 4 Unknow
							248 Was s	n autopsv	24b. W	ere autopsy findings
							perfor	med?	av	ailable prior to mpletion of cause
			F-65-17		7					death?
							1 D Y	es MNo	10	Yes No
25 Was case referred to modil	cal				ac Di	and of Dooth				,
examiner?		tal: 🛶			Other					
		Inpatient			40					y)
		Ba. Dete of Injury (Month, Dey Yee)	28b. Tima o	280			zed. Describe h	ow injury occur	Der	
						DNo				
2 Accident Inves	stigetion			М	1 ☐ Yes 2	D140				
2 Accident Inves	stigetion	9e. Place of Injury - A building, etc. (Sp.	It home, farm, st				28f. Location (S City or Tow		er or Rure	of Route Number.
	Bertha Marie 4a Facility Name (If not Institut St. Mary's 5. Social Security Number 160-03-1249 Usual Residenca of Decedent 10a. State 10b. Count Maryland St. 10a. Street and Number 23359 Green Ho 11. Marital Status 1 Nevar Married 2 M 3 Widowed 4 Divorce 15. Deced (Specify only high Elementery/Secondery (0-12 th) 17. Fathar's Name (First, Middle John J. Shafter Shame (First, Middle John J. Shafter Shame (First, Middle John J. Shafter Shame) 19a. Informant's Name/Relation Patricia Gaid 20e. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other 21. Signature of Funeral Service 23a. Part 1. Enter the disease, shock, or heart feilure. It is immediate Cause (Final disease or condition resulting in death) Sequantially list conditions, if any, laading to immediate cause. Enter Underlying Ceuse (Disease or injury Ihal initiated events resulting in death) Part II. Other algnificant conditions of the condition of the con	St. Mary's Hospital 5. Social Security Number	Bertha Marie Duff 4a Facility Name (If not Institution, give street and number) St. Mary's Hospital 5. Social Security Number 160-03-1249 Usual Residence of Decedent 10a. State 10b. County Maryland St. Mary's 10a. Street and Number 23359 Green Holly Road 11. Marital Status 1 Never Married 3 [Xwidowed 4 Divorced 15. Decedent's Education (Specify only highest greda completed) Elementery/Secondery (0-12) 12th 17. Fathar's Name (First, Middla, Last) John J. Shaffer 19a. Informant's Name/Relationship (Type, Print) Patricia Gaidish (Daughter) 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, of complications that caused the disease or condition resulting in death) Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury hala initiated events resulting in death) Part II. Other algnificant conditions contributing to death but not death of the sequence of the Underlying Cause (Final Sease or condition resulting in death) Part III. Other algnificant conditions contributing to death but not death of the sequence of the seq	1. Decedent's Name (First, Middle, Last) Bertha Marie Duff 4a Facility Name (II not Institution, give street and number) St. Mary's Hospital 5. Social Security Number	1. Decedent's Name (First, Middle, List) Bertha Marie Duff 4a Facility Name (# not Institution, give street and number) St. Mary's Hospital 5. Social Security Number 16. Sax 1 104 22	1. Decedent's Name (First, Middle, Last) Bertha Marie Duff	1. Decedent's Name (First, Middle, Last) Bertha Marie Duff 4s Facility Name (If not Institution, pive street and number) St. Mary's Hospital 5. Social Security Number 16. Cay, Town, or Loc 16. County 16. Cay, Town or Localison 16. County Maryland St. Mary's 10c. City, Town or Localison 10c. State 10b. County Maryland St. Mary's 10c. City, Town or Localison 10c. City, Town or Localison 10c. Street and Number 10d. Street and Number 10d. Street and Number 10d. Street and Number 10d. Street and Number 11d. Nerval Street and Number 11d. Nerval Maried 11d. Nerv	Bertha Marie Duff 4s Facility Name (if not institution, give streat and number) St. Mary's Hospital 5. Social Security Number 6. Sax 160-03-1249 10c. Clay, Town of Location of Death Leonardtown 10s. State 10c. County Maryland 10c. Clay Town of Location Levington Park 10s. Streat and Number 23359 Green Holly Road 11. Marial Status 11. Specificity State 12. Was Decedent Even in U.S. Armed Forcas? 11. Marial Status 11. Specificity State 12. Was Decedent Even in U.S. Armed Forcas? 11. Marial Status 12. Was Decedent Even in U.S. Armed Forcas? 11. Marial Status 12. Was Decedent Even in U.S. Armed Forcas? 11. Marial Status 12. Was Decedent Even in U.S. Armed Forcas? 11. Marial Status 12. Was Decedent Even in U.S. Armed Forcas? 11. Marial Status 12. Was Decedent Even in U.S. Armed Forcas? 11. Marial Status 12. Was Decedent Even in U.S. Armed Forcas? 11. Marial Status 12. Was Decedent Even in U.S. Armed Forcas? 12. Was Decedent in Status 13. Was Decedent in Hispanic Origin? (Specify vas or Noil Widew Armed Forcas?) 13. Was Decedent in Hispanic Origin? (Specify Vas or Noil Was or Noil W	1. Decedent's Name (First, Middle, List) Bertha Marie Duff	1. Decoder's Name (First, Middle, Leal) Bertha Marie Duff 4e Febility Name (First Middle, Leal) Bertha Marie Duff 4e Febility Name (First Middle, Leal) St. Mary 'S Hospital 5. Social Souriey Number 6. Sax (Nary 'S Hospital 1. Social Souriey Number 6. Sax (Nary 'S Hospital 1. Social Souriey Number 6. Sax (Nary 'S Hospital 1. Social Souriey Number 1. Social Social Social Number 1. Social Social Social Number Number 1. Social Social Social Social Number Number 1. Social Social Social Social Number Numb

BERTHA MARIE DUFF

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. DAVID RATCLIFF CALIAFORNIA, MD. 20619

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

35040

29d. Date signed (Month, Dey, Year)

State Registrar

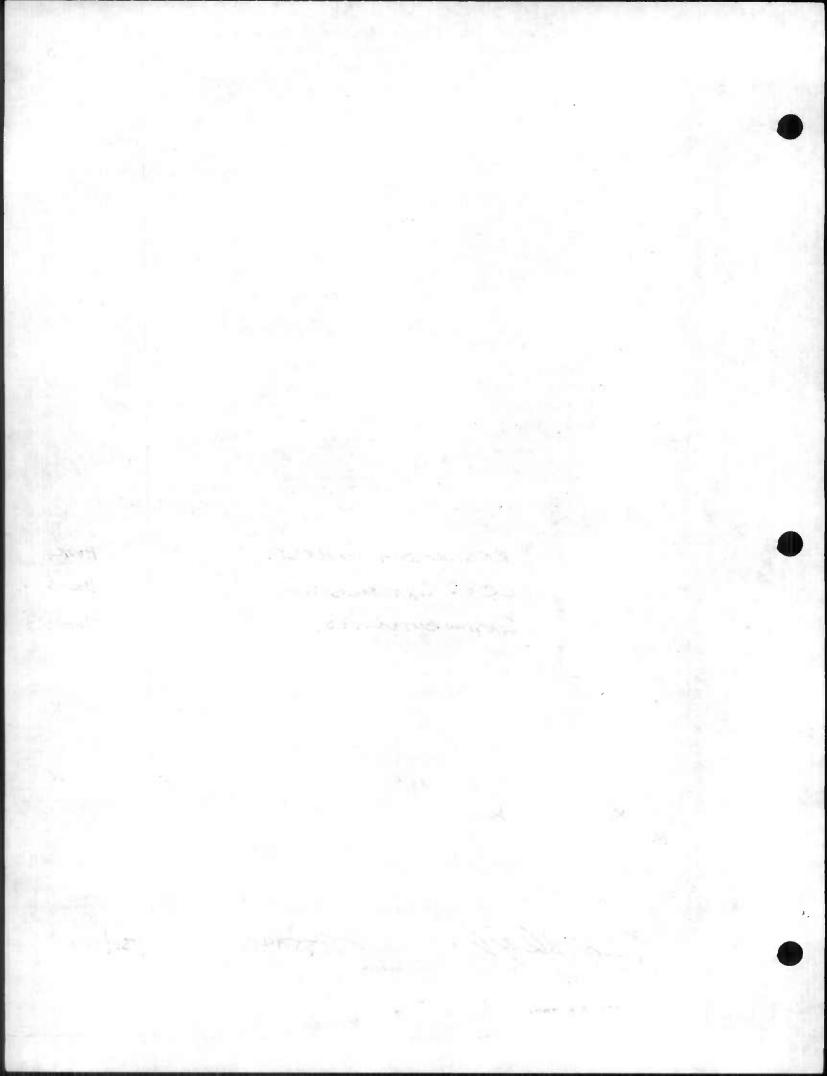
Medicai (

29a. Certifier

29b. Signati

31. Date filed (Month, Dey, Year)
JAN 0 3 2001

32. Registrar's Signatura



Box 68760

emit. Pages 1 and 2 should be Repartment of Health and Mantal Important: If New 27 is marked o

Physician /Medical

Examiner

Physician

/Medical

Examiner

Director

Funeral

ğ

Completed

10a. Stete

Funeral

Director

the Medical Examiner must be notified

of Vital Records,

Division

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death DECEMBER 28. 2000 11:20AM Mary Elizabeth Jones 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's 5. Sociel Security Number 6. Sex If Under 1 Yeer 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Deys Hours Min 1□M 2√F Yrs 579-38-7460 73 January 11, 1927 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland St. Mary's Leonardtown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 22810 Dorsey Street Apt. 303 20650 U.S.A. 14. Race - Americen Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Self Employed Housekeeper Private Homes 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Unknown Unknown 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Mary Louise Morgan (Friend) 22810 Dorsey Street, Apt. 304, Leonardtown, Maryland 20650 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremetion 3 ☐ Removel from State 12/29/00 Alexandria, Virginia 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Mattingley-Gardiner Funeral Home, P.A. Jardener P.O. Box 270, Leonardtown, Maryland 20650 Approximete Intervel Between Onset and Deeth 23a. Pert1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock or heart feilure. List only one ceusa on each line. Immediate Cause (Finel disease or condition resulting in deeth) Due to (or as e consequence Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Couse (Disease or injury Due to (or es e consequence of) thet initieted events resulting in death) Last Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 25. Wes cese referred to medicel examiner? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Date of Injury
(Month, Dey Year)

2 ER/Outpatient 3 DOA
28c Time of Injury
28c 27. Menner of Death 28d. Describe how injury occurred Injury et Work? 1 Accident 5 Pending investigation 1 Yes 2 No 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 T Homicide

Physician/Medical Examiner detached the th been signed by should be detac P Completed page 2 has Be

attending physician and for use as the burial-transit certificate be executed The law requires that the death Director: After this certificate in by the funeral director, pag Physician: 10 Certification: or Attending death. after

3

DHMH 16 Rev 6/95

within 24 hours a To the Funeral C Registrar

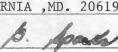
29b. Signeture end title of certifier DR.

29a. Certifier

dical

JAMES C. BOYD 31. Dete filed (Month, Day, Year) JAN 04 2001

32. Registrer's Signeture Deneron



1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s)

29c. License number

99

29d. Date signed (Month, Day, Year)

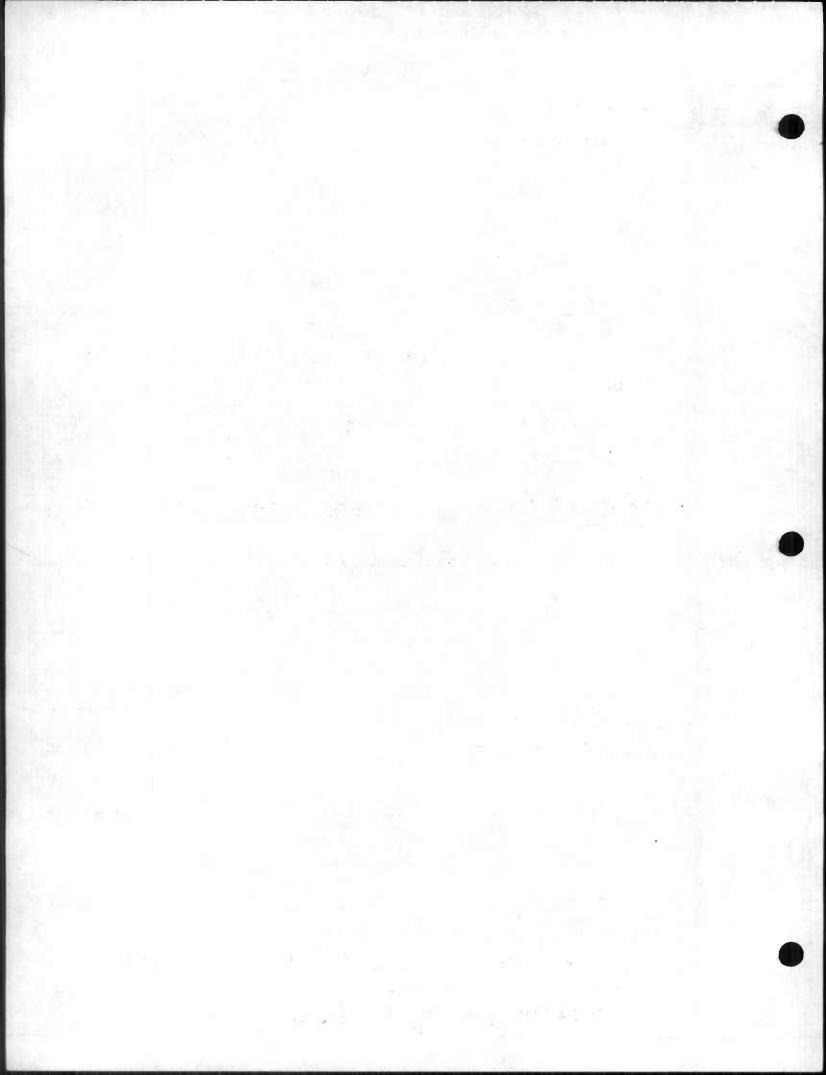
ORIGINAL

30. Neme and address of person who ca

se of death/(item 23a) (Type, Print)

end menper stated.

CALIFORNIA MD.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

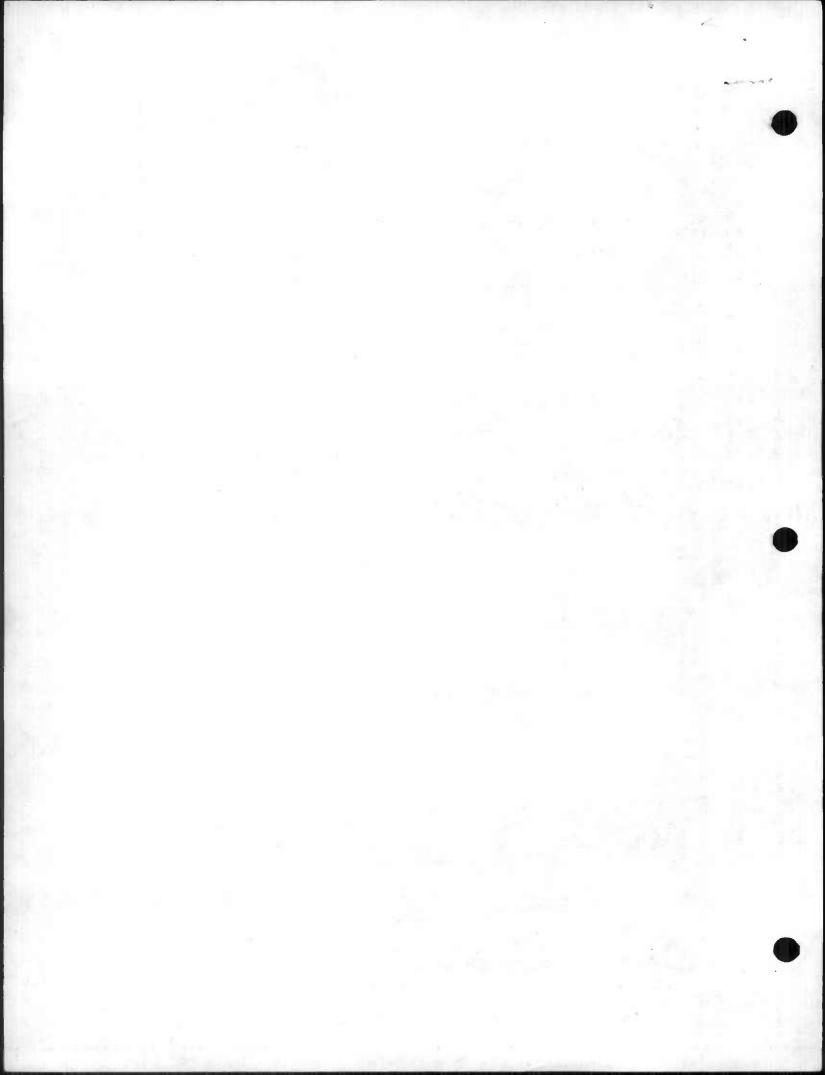
State of Maryland / Department of Health and Mental Hygiene 1 4 3 5 9 5

Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** James H. Keaton 31, 2000 December 9:15PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George Community Hospital Cheverly, MD.
If Undar 24 Hrs. 8. Date of Prince George 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 1 Yaar 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. 1⊠M 2□ F Months Days Hours Director 232-24-8537 79 June 21, 1921 Beckley, Usual Residence of Decedent Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ehow mass be notified at 1⊠ Yes 2 No Directo Maryland Prince George District Heights the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1202 Waterford Drive 20747 United States Funeral |tems 12. Was Decedent Evar in U.S. Amed Forces? 1 ≦Yas 2 □ No It Yes, Giva Year or Dates: Unknown Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 Nevar Married 2 Married 21215-0020 natural', or 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed th and Mental Hygiene.
7 Is marked other than "natur treumstic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Mail Clerk U S Postal Service 12th Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) . Pages 1 and 2 should be filt ment of Health and Mental Hant: If hem 27 is marked oth jury or other treumatic even Be Arthur Keaton Willie Mae Talley 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alpha Keaton/Wife 1202 Waterford Dr. District Heights, MD. 20747 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State Burlal 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. Washington National 1/5/2001 Suitland, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Space Licenso 22. Name and Address of Facility Pope Funeral Homes, 5538 Marlboro Pike Forestville, MD. 20747 23a. Part 1. Enter the disease or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 1 and List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disaasa or condition resulting in death) 2000 + Examiner Examiner sician and burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): 88 USB signed by the at P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hilknown Division of Vital Records. Completed by 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? page 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 | Inpatient 2 | EN/Outpatient 3 | DOA this funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural efter death.

Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined within 24 hours efter de To the Funerei Directo completaly filled in by th 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier the state 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 and address of person who completed cause of death (Item 23a) (Type; Print) SUTLAND, MD 20746 GINALI 5100 AUTH 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 1 6 2001 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelibie Ink. Assure All Copies Are pegible 4 3 5 9 6 State of Maryland / Department of Health and Mental Hygiene

		(Certificate	of Deati	h	Reg. No.					
	1. Decedent'a Neme (First, Middle, Last)				2. Dete of E	Peeth	3. Time of Dee				
Physician	Mary Regina		Mill	er	Month		000 5:15 p				
/Medical Examiner	4a Facility Name (If not institution, give street and number)	Tage 1			Town, or Location of Dec						
	Asbury Health Care Center			Solo	mons Island	Cal	vert				
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthe	dey) If Under 1 \	Year If Under	Min. 8. Date of E	lirth	9. Birthplece (State or For Country)				
Director	579-07-7015 1□M 2♥F 87	Yn	s. Months D	ays Hours			3 Maryland				
9	Usual Residence of Decedent										
E .		0c. City, Town o			10d. Inside						
28e-f.s 28e-f.s notified ector	Maryland Calvert	Solo	mons				1 Yes 2 7				
or 28e-f show be notified at Director	10e. Street end Number		10f. Zip Co	ode		10g. Citizen of Wh	at Country?				
S S S S S S S S S S S S S S S S S S S	11750 Asbury Circle			20688		USA	4				
The The	11. Maritel Status 12. Was Decedent Ev Armed Forces?	er in U,S.	13. Was Deceden		Origin? (Specify Yes or It en, Puerto Rican, etc.)		- American Indian, White, etc.				
T min	1 Never Married 2 Married 1 Yes 2 No		1 Yes 2 🖫				Willia, etc.				
b 6.	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Yeer or Dates:		10 105 22	1140 Specii	у.	Specify:	White				
ygens. er than 'natur t, the Medical Completed	15. Decedent's Education	16a. D	ecedent's Usual C Give kind of work of	Occupation	net of working	16b. Kind of Busi	ness/Industry				
ble Mar	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		ife. DO NOT use i	retired)	ost or working						
State of	8th Grade		Restauran	t Mana	ger	Rest	aurant				
d othe event	17. Father's Neme (First, Middle, Last)			18. Mot	her's Name (First, Midd	le, Maiden Sumeme)					
Menta wheel whice To	Harry McCorn	nick		R	ose	Jo	hnson				
N DG V	19a. Informant's Name/Relationship (Type, Print)	19b. N	Malling Address (S	treet and Num	ber or Rural Route Num	ber, City or Town, S	tete, Zip Code)				
n 27 is	Linda O'Connell (Grandaughte	r) P.	O. Box 4	36. Po	rt Republic	Marylan	d 20676				
1 1 1	20a. Method of Disposition	20b. Plece of D	isposition (Name crematory or othe	of	Date	20c. Location - C	ity or Town, State				
A H	1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)				ry 1///200	Levingto	n Park, Mary				
The state of		I IIIII C G I C					il Tark, Hary				
Dep Mary	21. Signature of Funeral Service Licenses 22. Name and Address of Facility Brinsfield Funeral Home, P.A.										
depote the second	Mary B. Rizzo M01114)		P.O. Bo	ox 279,	Leonardto	vn, Maryla					
	23a. Part1. Enter the disease, or complications that caused the shock, or hear failure. List only one cause on each line.	e death. Do no	t enter the mode o	of dying, such a	as cerdiac or respiratory	arrest,	Approximate Interval Between Onset and Deat				
hysician							Oriset and Deat				
/Medical Examiner	Immediate Cause (Finel disease or condition	CV.	4								
	resulting in death)	ue to (or ea a co	nsequence of):								
i i	- h	ANT	HMA								
hysician end the bunal-transit dical Examir	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying										
g physician end as the burial-tra	Cause (Disease of Injury C.										
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e attending of for use a	d						1				
0 0 0	Part II. Other eignificant conditions contributing to death but	not resulting in t	he underlying ceu:	se given in Pe	rt I. 23b. Di	d tobacco uee cont	ribute to the ceuse of de				
een signed by the hould be detached by the hould be detached by the steel by Phys	LIT N	4.	rato.		-1(Y00 2 00	3 Probably 4 Unk				
be de	7//	LAP	erten	AILN			TT-1MILL				
on sing		- 1		-	24a. W	as en autopsy rlormed?	24b. Were autopsy finding available prior to				
as be 2 sho							completion of cause of death?				
ate has been s page 2 should					11	Yes 2 No	1 ☐ Yes 2 ☐ No				
or. p	25. Wes cese referred to medical			ge Di-	ace of Death (Check on)						
r this certificate has b aral director, page 2 s	examiner? Hospital:	ما حادث	national off post	Other			(Consib.)				
this certific ral director.			ne of 28c		Nursing Home 5 Re	e how injury occurre					
at Director: After the funeral led in by the funeral Certification:	Deletural 5 Pending (Month, Dey)	(ear) Inju	ury	. Injury at Work? 1 ☐ Yes 2			1 - 1 - 1				
To the Funeral Director: After this completely filled in by the funeral Medical Certification: 1	3 Suicide 6 Could not be	. At home farm				(Street and Number	r or Rurel Route Number,				
in the	4 Homicide determined 256. Piece of mjury building, etc.	(Specify)	n, street, lectory, t			own, Stete)					
De les	One Continue	nu la cuta t	de eth e	the steel of the	and stage and 4 a 4 m	10 0014c/s\ == d ==	nor on stated				
n 24 hound he Funer pletely fill	29a. Cartifier (Check only 2 Medical Examiner: On the basis of e	kamination and/									
Med Med	one) and manner stete	d.	20- 1	loones		20d Date sizes	(Month Chu Vees)				
N CO	29b. Signeture and title of continer	4	290,1	icense numbe	77 47		(Month, Day, Year)				
) csey/ Joen			Dac 2	1476	JAN.	03,200,				
/	30. Name and address of person who completed ceuse of dea	th (Item 23a) (T	ype, Print)								
	John Barth, MD		Prince	e Frede	rick, Mary	land					
State	31. Date filed (Month, Day, Year) 32. Registrar	s Signature	1 1								
Registrar	JAN 0 5 2001	mar	D. 10	melle,							

The Things

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.,

If Under 1 Year | If Under 24 Hrs. Months | Deys | Hours | Min.

8. Data of Birth (Month, Dev. Year)

June 29, 1913

Birthplaca (Stata or Foraign Country)

10d. inside City Limits

1 ☐ Yes 2√ No

Pennsylvania

US

A

White

14. Rece - American Indian, Black, White, atc.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Barbara Povlic 30, 2000 5:03 p.m. December 4b. City, Town, or Location of Death 4e Fecility Nama (If not institution, give street and number) 4c. County of Deeth Fort Washington 12204 Autumnwood Lane Prince George's

/Medical **Examiner Funeral** Director r than "natural", or items 23s or 28s-f show the Medical Exampler must be notified at Pages 1 and 2 should be filed within 72 hours after death neart of Health and Mehal Hyghens.

This marked other than "tatural", or theme 23 mry or other traumatic event, are review from many or other traumatic event, are 3altimore, Maryland 21215-0020 Department of Important: If it any injury or o

Physician

Marv

5. Sociel Security Number

192-03-7023

Usuel Rasidance of Dacedant

þ Completed 8 **Physician** /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be axecuted use as t þ paga 2 should After this cartificate To the Hospital or Attending Physician:

Box 68760.

P.O.

Records,

Division of Vital

death.

after death

within 24 hours a To the Funeral C completaly filled

filled in by

10a Stata 10h County 10c. City. Town or Location Maryland St. Mary's California Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 22912 Three Notch Road 20619 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 1 Yas 2 No If Yes, Giva Yeer or Datas: 1 Nevar Married 2 Married 1 ☐ Yes 2 ☑ No Specify. 3 ☑ Widowad 4 ☐ Divorced 15. Decedant's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 16h Kind of Business/Industry Elementary/Secondary (0-12) 8th Grade College (1-4or 5+) Beautician Beauty Salon 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maidan Surname) Andrej Drnjevich Maria Milich 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 20653 19e. Informant's Name/Raletionship (Type, Print) Leila P. Grimsley (Daughter) 20b. Place of Disposition (Nama of cametery, crametory or other place) 20a. Mathod of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Ramoval from Stata Grandview Cemetery 4 □ Donation 5 □ Othar (Specify) Du 22. Name and Address of Facility Edward N. Brinsfield, Jr. M00052 23a. Part1. Enter the disaasa, or complications that ceusad the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or haert failure. List only one cause on each line. Immediata Causa (Final diseasa or condition resulting in deeth) Due to (or as a consequence of): Sequantially list conditions, if any, leading to immediate ceuse. Enter Undarlying Causa (Disaasa or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the undartying cause given in Part I. Be Completed 25. Was case rafarred to medice! 26. Placa of Death (Check only one) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28b. Tima of Injury 27. Mannar of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury at 1 Natural
2 Accidant 5 Panding invastigation 1 Yas 2 No 6 Could not be datemined 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, daeth occurred et the time, date and plece, and due to tha causa(s) and mannar as stated.

2 Medicel Examiner: On the basis of examination end/or investigation, in my opinion, daeth occurred at the time, date and place, end due to the cause(s) and mannar stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and titla of certifian 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LINE CENTRY WAYONF, Md. 2060

7. Age (In yrs. last birthday)

87

Yrs.

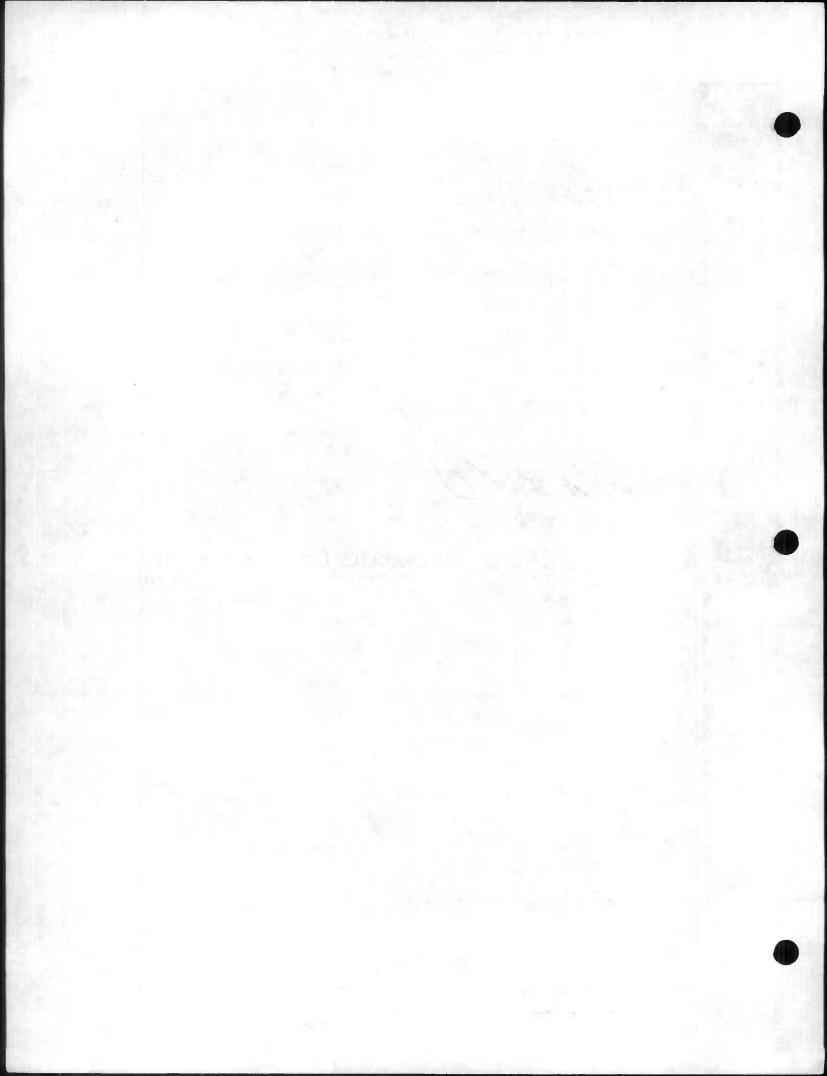
1□M 20 F

22994 Town Creek Drive, Lexington Park, Maryland of Disposition (Nama of Data 20c. Location - City or Town, Stata 1/5/200 Export, Pennsylvania Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650 Approximete Intarval Batween Onset end Death (ALDIOUASCULAR 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings aveilabla prior to complation of cause of deeth? 24a. Wes an autopsy 1 Yas 2 No 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 8 Other (Specify) Residence 28d. Dascribe how Injury occurred 281. Location (Street end Number or Rural Routa Number, City or Town, Stata) 29d. Data signed (Month, Day, Year) 32. Registrar's Signature **ORIGINAL**

State Registrar

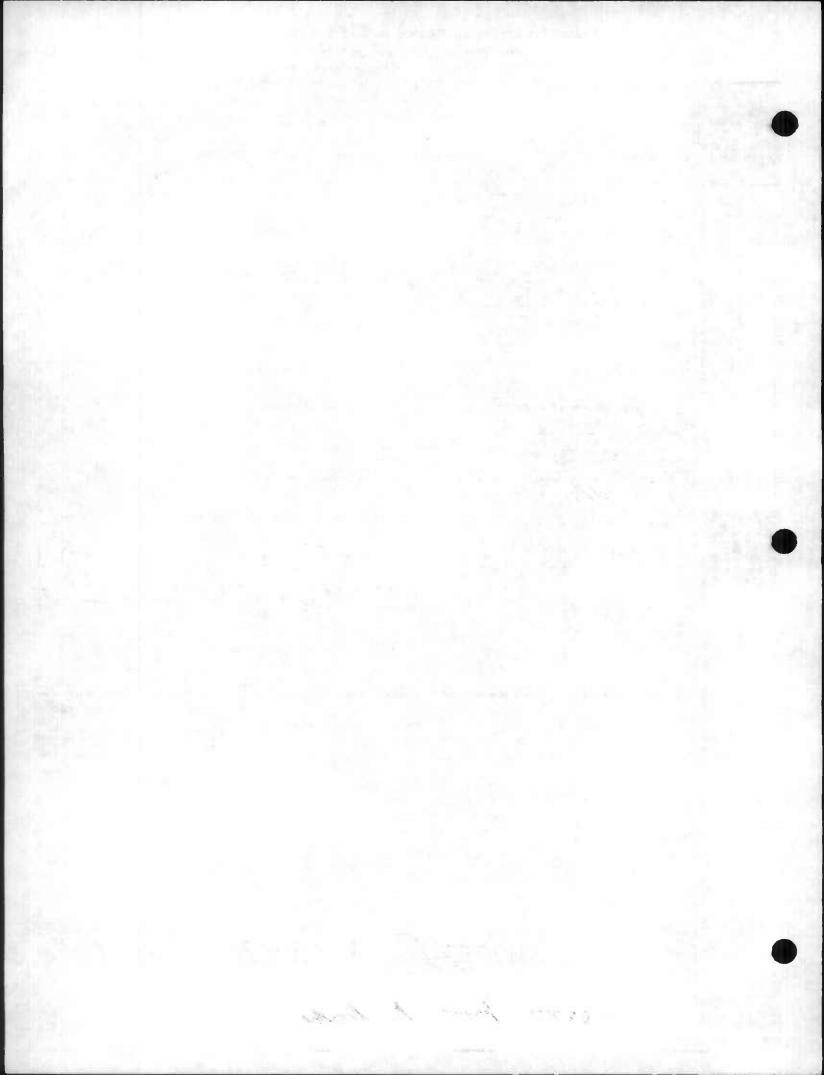
31. Data filed (Month, Day, Year)

JAN 03 2001



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

	State	of Maryland / D	epartment of l			ene 00 4	3598
	Decedent's Name (First, Middle, Last)				2. Date of Death	Day Year	3. Time of Death
Physician /Medical	Clarence Richard	Rora	bacher		December	30, 2000	9:15 p.m.
Examiner	48 Facility Name (If not institution, give street and 21433 Onion Fields La			4b. City, Town, or Le Californ		4c. County of Deeth St. Mary	
Funeral Director	5. Social Security Number 220-28-6605 Usual Residence of Decedent	7. Age (In yrs. last birth	Months Days		8. Date of Birth (Month, Day, Y August 2	9. Birth Cou 9,1932 Mic	place (State or Foreign intry) higan
Jend Mend	10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
of the Mention of the Men	Maryland St. Mary's	Cali	fornia				1 ☐ Yes 2 Î No
or 28s-f a	10e. Street and Number		10f. Zlp Code		100	. Citizen of What Cou	intry?
23a 23a	21433 Onion Fields La	ne	206			United Sta	
r hame 234	Armed	ecedent Ever in U,S. Forces?	 Wes Decedent of If Yes, specify Cul 	Hispanic Origin? (Sp ban, Mexicen, Puerto	ecity Yes or No- Rican, etc.)	14. Rece - Amer Bleck, White	
e i i	1 Never Married 2 Married 1 Yes, 3 Widowed 4 Divorced Year of	es 2 No 1954 Give 1957	1□ Yes 2□ No	Specify:		Specify: Wh	ite
ed within 72 hours ygiene. nor then "netural; rt, tre the sice [E.	15. Decedent's Education (Specify only highest grade complete	(d)	Decedent's Usual Occur Give kind of work done	e during most of work	ing 16	b. Kind of Business/I	ndustry
within ene.	Elementary/Secondary (0-12) College	e (1-4or 5+)	o Body Rep		ician	Automotiv	re
	17. Father's Neme (First, Middle, Last)			· · · · · · · · · · · · · · · · · · ·	e (First, Middle, Ma		
Mental H Mental H arked oth artc aver	Floyd Rorabacher				Jospehine		
d 2 should be file th and Mental Hy 7 is marked othe traumatic avent To Be	19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Stree				ip Code)
	Mary V. Rorabacher W	ife 214	33 Onion F	ields Lane	e, Califo	rnia, Mary	land 20619
permit. Peges 1 er Department of Hea mportant: If Nam 2 any Injury or other anges.	20a. Method of Disposition 1 □ Burla1 2 □ Cremation 3 □ Removal fro	20b. Place of I	Disposition (Name of , cremetory or other pla			c. Location - City or 1	
at the death certificate be executed The death certificate be executed The death of the set of th	23a. Part1. Enter the disease, or complications for shock, or heart failure. List only one cause of the cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	morna Seequence of):	Can	CQ)		Approximate Interval Between Onset and Deeth
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e law requires th has been signed ge 2 should be d					24a. Wes an performe	od?	Were autopsy findings aveilable prior to completion of cause of death?
certificate rector, par Be Co	25. Was case referred to medical			26 Place of Dee	th (Check only one)	N	20140
	examiner? Hospital:	☐ Inpatient 2 ☐ ER/Out	patient 3 DOA	Whor:		ce 6 ☐Other (Spec	eifu)
Physer this seral dieral d	27. Manner of Death 28a. De	te of injury 28b. Ti	me of 28c. Inj		28d. Describe how		,/
rs after death at Director: After led in by the funers Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Pl.	ace of Injury - At home, fari	M 1[☐ Yes 2☐No	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	29a. Certifier Certifying Physician: To	the best of my knowledge,			and due to the cau	se(s) and manner as	
he Hospi in 24 hou he Funer pletely fil	(Check only one) Medical Examiner: On the and m	e basis of examination and anner stated.	or investigation, in my	opinion, death occur	red at the time, dat	e and placa, end due	to the cause(s)
Within To the company	29b. Signature and little of certifier	1 101	29c. Licer	nse number	290	d. Date signed (Monti	n, Day, Year)
	1 ARM HAM	NEW	D	0641	9	-2-0	
	30. Name and address of person who completed c	ause of death (Item 23a) (1	Type, Print)	1			
-	J. Vatrick Varboe,	M.D.	Hollywoo	d, Marylan	nd		
State Registrar		. Registrer's Signature	B. Som	d, Marylan			



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Genetta 31, 2000 December 9:42 PM 4a Facility Neme (ff not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Bethesda, Suburban Hospital MD Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
April 23,1946Scotlandneck, NC 5. Social Security Number 7. Age (fn yrs. fest birthday) Months Days Hours Min 1 □ M 2 🛱 F 578-74-4311 54 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1€ Yes 2 No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20018 2513 14th Street NE, Apt #4 United States Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2□ Married 1 ☐ Yes 2 ☑ No If Yes, Give X 1 ☐ Yes 2 ☑ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Server Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Lest) Ellen E. Norfleet Percy Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Moore / Sister 3341 23rd St, SE, #101, Wash, DC 20020 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 1/5/01 Chesapeake Crematory Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Pope Funeral Homes Simmons ann 7. 5538 Marlboro Pike, Forestville, MD 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1) reumous Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as e consequence of): Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Jahnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 □ Yes 2 □ No 2 NO 25 Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Menger of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Panding Injury 1 Yes 2 □ No Investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State)

of Vital

Examine Physician/Medical P Completed Be Certification: To *ctor:

Physician

Examiner

Funeral

Director

or items 23s or 28s-f show

"natural".

then

permit. Pages 1 and 2 should be file Department of Health and Mental Ly Important: if Nem 27 is marked oth any linjury or other traumatic avent DAB.

Physician /Medical

Examiner

event, the Medical Examiner must be notified at

Director

Funeral

þ

Completed

DC

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0020

/Medical

Box 68760 Records, Division The Hospital Thin 24 hours at the Funeral C

> State Registrar

Medical

29a. Certifier

29c. License number 05

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

MMM

30. Name and address of person v completed ceuse of death (Item 23a) (Type, Print)

Goldstein M.D. 8600 Old Georgetown Rd. Bethesda, MD Elbert K.

Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

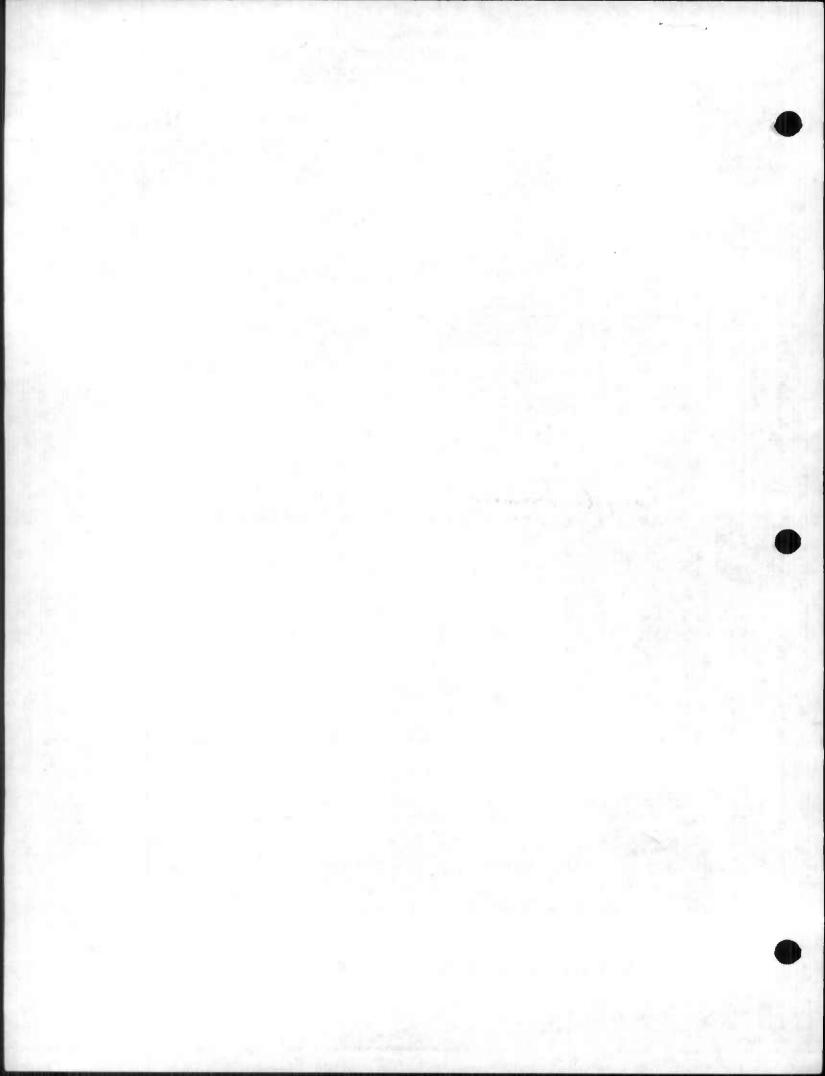
31. Date filed (Month, Dey, Year) JAN 1 9 2001

29b. Signature and title of certifie

32. Registrar's Signature

poorky **ORIGINAL**

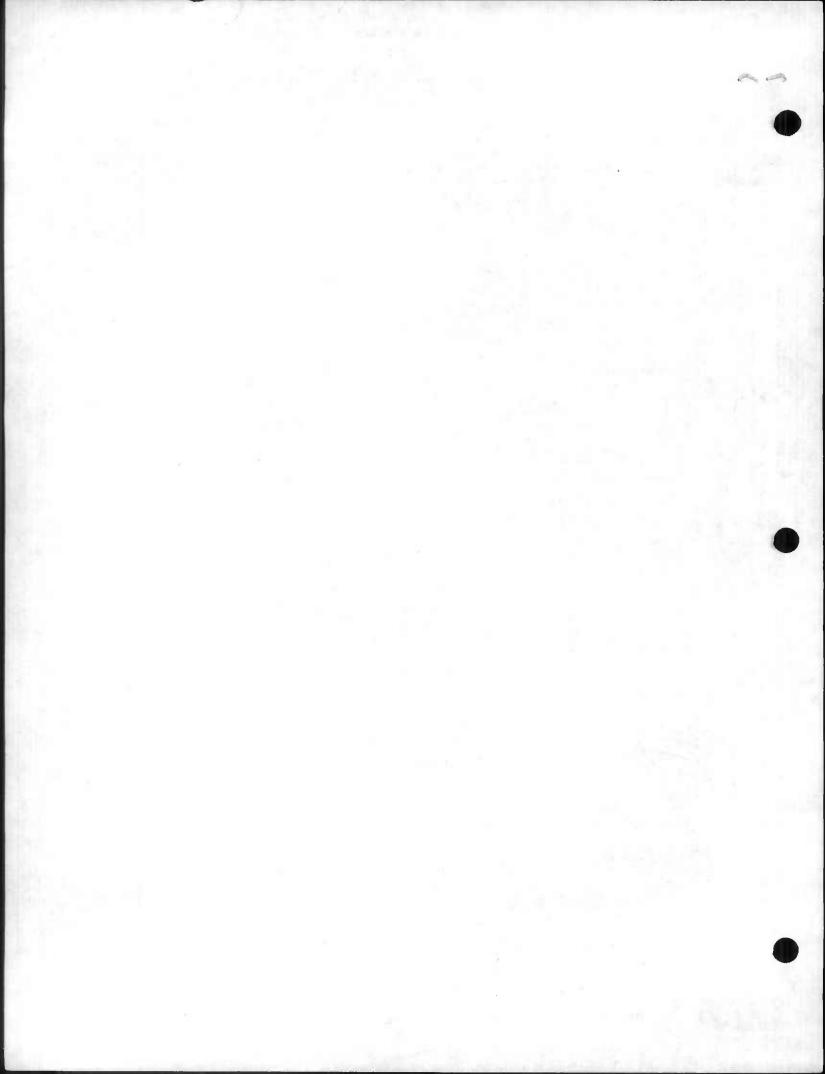
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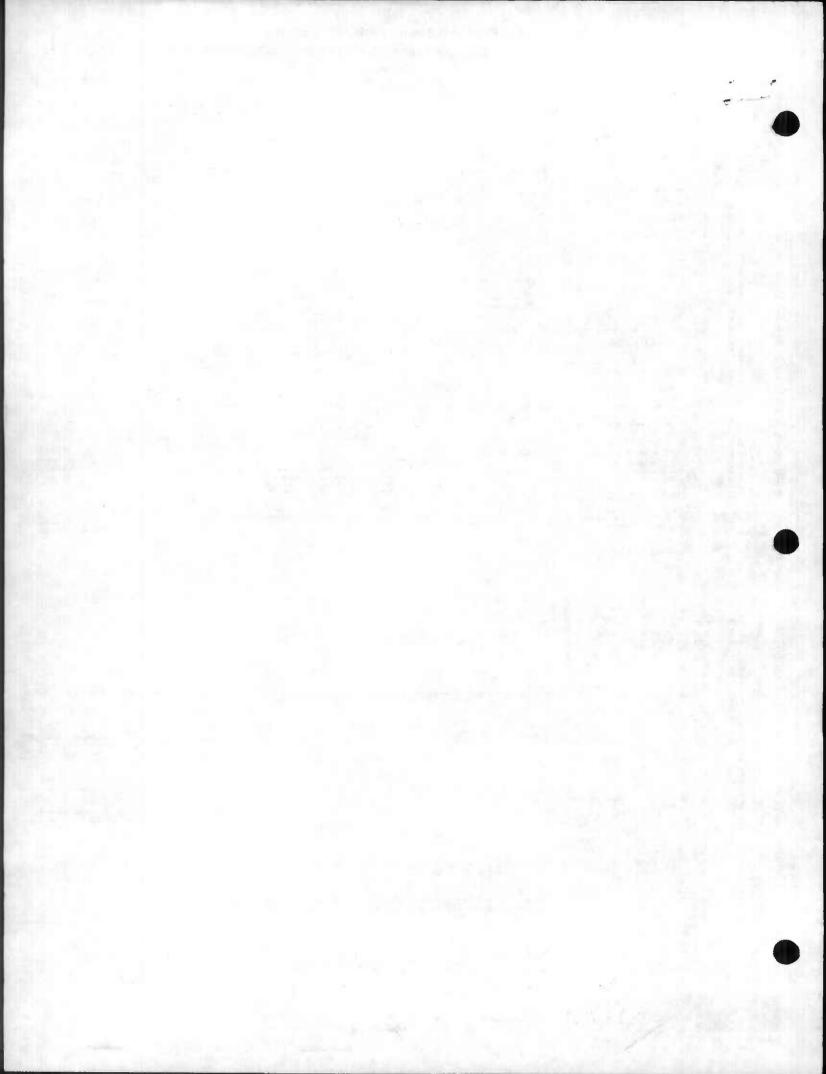
						Cert	ificate	e of	Death			Reg. No				
ian ical	1. Decedent's Name (First, Manual James		ith								2. Date of D Month 12	eath Day 20	20	Year 00	3. Time of Death 12:25	1
	4a Facility Name (If not institu Mariner Hea				n Mar	vland	1	4	b. City, Town		cation of Dea		County o		rges	
	5. Social Security Number 578-72-2063	6. Sex	VI 2□ F		yrs. last b	birthday)	If Under	1 Year Days	If Under 24		8. Date of B (Month, D	irth ay, Year)		9. Birthp Coun	lace (State or Fore	nign
	Usual Residence of Decedent										09-12	-53		D. (
_	10a. Stata 10b. Cou	nty		10		wn or Loca								1	0d. Inside City Lim 1 ☑ Yes 2 ☐ I	3.1
Director	D. C.				was	shing									1	40
	10e. Street and Number			164			10f. Zip						izan of Wi		try?	
runeral	1117 Eye S			E.	r in U.S.	13. W		0002 ent of H	lispanic Origin	? (Spe	cify Yes or N		. S.		an Indian,	
	1 Never Married 2 N	larried	Armed F	orces? 2 No ive			Yes, spec		lispanic Origin an, Mexicen, P Specify:	uèrto F	Rican, etc.)			, White,	etc.	
Completed	15. Dece (Specify only hig	ient's Educe	tion		16	Sa. Decede	ind of wor.	k done	during most of	workir	70	16b. K	ind of Bus	iness/Inc	dustry	
ă l	Elemantary/Secondary (0-1			(1-4or 5+)		life. Do	O NOT us	e retired	3)			M	CI			Ш
	17. Father's Nama (First, Midd	lla (ast)				Te.	LeCon	ımun	ication		(First, Middl)		
Q Q	Earl Smith	re, Last)									Willia		Cumanio	,		
0	19e. Informant's Name/Relati	onship (Type	e. Print)		19	9b. Mailing	Addrass	(Street	and Number of				or Town, S	itate, Zip	Code)	
	Olive M. F			Cousi					P1.,							
1	20a. Method of Disposition			1	20b. Place	of Disposi	ition (Nam	e of	na)		Date	20c. L	ocation - C	ity or To	wn, State	
	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Othac		moval from	Stata					Crema	tor	v 01-1	2-01	Arlin	gtor	ı. Va.	
1	21. Signature of Funeral Serv						Name and	d Addre	ss of Facility					8 -0 -	.,	
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-	23a. Part1. Enter the disaase shock, or heart failure. It tramediate Cause (Final disease or condition resulting in death)	lst only one		Se Rec	phic	en,	خ		ig, such as ce	TOTAL O	Tespiratory	arrest,		1	Approximate Interval Batween Onset and Death	
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Physician/Med		d														
sicia	Part II. Other significant cond	itions contri	ibuting to d	death but n	ot resulting	in the und	derlying ca	ause giv	ren in Part 1.		23b. Di	d tobacco	uss conf	tributs to	the cause of dea	ith?
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Completed by											24a. Wa par	is an auto formed?	psy	av	ere autopsy finding allable prior to mplation of ceuse death?	gs
E O											10	Yas 2	IDNo	10	Yes 2□ No	
Be	25. Was cese referred to med exampler?	ical							26. Place of	Death	(Check only	one)				
2	1 √ Yas 2 No	Но				Outpatient			4 LUNNUIS	-	me 5□Re			-	(y)	
ation:	27. Mannar of Death 1 Privatural 5 Pair 2 Accident	ding estigation	28a. Data (Mor	of Injury nth, Day Yo	28b	o. Tima of Injury	м 2	8c. Injur Wor 1 🔲	yat rk? Yes 2⊡No		28d. Describe	a how inju	iry occurre	•d		
Certification:		eld not be ermined	28e. Ptac build	e of tnjury ding, atc. (5	- At home, Specify)	farm, stree	et, factory	, office		- 2	28f. Location City or T	(Street all own, State	nd Numbe e)	or Aure	al Routa Number,	
edical C			r: On the b		amination a				ma, date end p pinion, daath						tated. o tha cause(s)	
Me	29th orgnature and title of cert	ifier	0		-		290	Licens	a number			29d. Da	ate signed	(Month,	Day, Year)	
	5		W.	-	-)	I	0004	6374		7	12	/22/0	00		
	30. Name and address of personal Anthony The 31. Date filed (Month, Day, Ye JAN 162	mas, I	M.D.	1	28 Sc	outhe			S.E.	Sui	te 312	. Wa	shing	gton	, D.C.200)32

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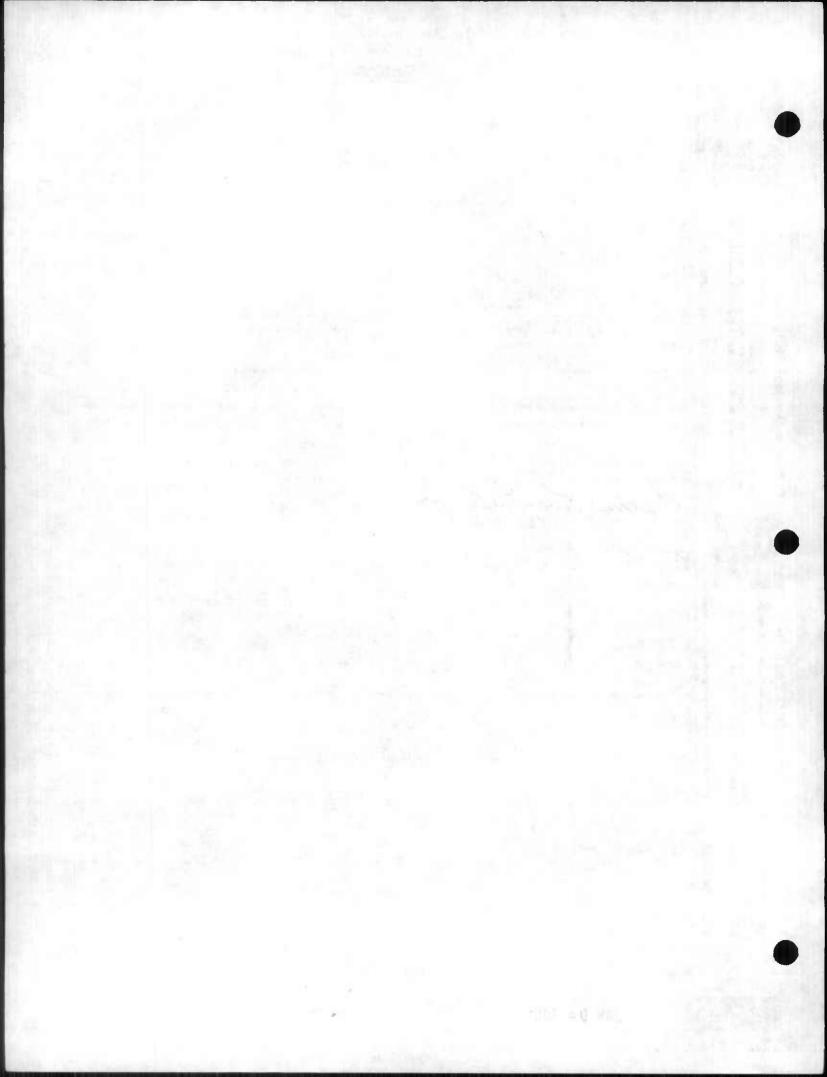
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1 # 9.P	er FH PGC 1-16-01 of 1. Decedent's Name (First, Middle, Lesi		Cei	tificate of	Death	Re 2. Dete of Deeth	g. No.		3. Time of Deeth	
Physician						Month		Year	The state of the s	
Medical	GRACE SMITH				0 0 T	DEC. 31	, 2000	1500	6:40 PM	
niner	4e Fecility Neme (If not institution, give				4b. City, Town, or Lo		4c. County o	Deeth		
	CHESEPEAKE HOSPI		'In yrs. last birthdey)	If Under 1 Year	LINTHICUM If Under 24 Hrs.		ANNE A			
al or	3/3-00-4/13	M 2∑F	51 Yrs.	Months Deys	Hours Min.	8. Dete of Birth (Month, Dey, APRIL	Year) 25, 194	Country 9 U.S	ce (State or Foreign y) unknown	
	Usuel Residence of Decedent 10a. Stete 10b. County	1	Oc. City, Town or Lo	cation		100		100	d. Inside City Limits	
tor	MARYLAND PRINCE G		SUITLA						1 Yes 2 □ No	
Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wi	hat Countr	y?	
	2305 BROOKS DRI	VE #104		207	46		UNITED	STAT	ES	
Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U,S. 13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecity Yes or No-	14. Rece	- Americai	n Indien,	
by	1 Never Married 2 Merried 3 Widowed 4 MDivorced	1 Yes 2 No If Yes, Give Year or Detes:		Tes, specify coo.	Specify:	Thous, ord.,			-AMERICAN	
pete	15. Decedent's Edu (Specify only highest grad		16a. Deced	lent's Usuel Occup	pation during most of work		6b. Kind of Bus	siness/Indu	stry	Ì
Completed	Elementery/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	RECTTION (9			I
	12TH 17. Father's Neme (First, Middle, Last)		2211	· OI OOKI	18. Mother's Nemo		-	nown		
o Be	RUSSELL RO	99						"		
T	19e. Informant's Name/Relationship (T)		19b Mailir	ng Address (Street	EUCILLE end Number or Run		ROSS	State. Zip C	Code)	
	MARCIA SMITH/DAU			-	OR. #104,				20746	ı
	20e. Method of Disposition		20b. Plece of Dispo	sition (Neme of			20c. Location - C			
	1 ☑ Buriel 2 ☐ Cremetion 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			netory or other ple			T ATTE	OFT 1	MARYLAND	
	21. Signature of Funeral Service Licens	-		. Name end Addre	L CEM. JA	N. 6,200)1 LAUI	ر وللثلا	MAKILAND	
and	1 Laluard	m. F			NERAL HOM		T. RAIN	TED	MD 20712	
	23a. Pert1. Enter the disease, or comp	lications thet caused th	ne death. Do not ent	er the mode of dyi	E ISLAND			1	Approximate	-
ian	shock, or heart failure. List only o								Interval Between Onset and Deeth	
cal	Immediate Cause (Finel disease or condition	40	N6 0	ANC	FR					
er	resulting in deeth)	0.	ue to (or es a consec				- 115 10			4
lier l										
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D.	ue to (or es e consec	uence of):						
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Physician/M						l not Distant		1	the server of death 0	
ıysi	Pert II. Other significant conditions co	ntributing to death but	not resulting In the u	nderlying cause gi	ven in Peri I.				the cause of death?	
by PI						1010	2010	3071024	acity 4 distribution	
Be Completed I				73.36		24a. Wes er perform	n eutopsy ned?	evai	re autopsy findings ilable prior to ipletion of cause eath?	
omi						1 □ Ye	s 2ŽNo	10	Yes 2□ No	
O	25. Was case referred to medical				26. Place of Deat	h (Check only one	9)			
To B	examiner? 1 Yes 2 XNo	Hospitel:	2 ER/Outpatier	nt 3 DOA ON	her	ome 5 Reside		r (Specify)	HOSPICE	ĺ
Ition: 1	27. Menner of Deeth 1 Naturel 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Dey)	(ear) 28b. Time o	Wo	ry at rk? I Yes 2 □ No	28d. Describe ho	w injury occurre	ed		
Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (Str. City or Town	reet and Numbe , State)	er or Rural	Route Number,	
Medicai C		sician: To the best of a	xamination end/or in							
Medical Certification:	29b. Signature end title of certifier	0.	1	29c. Licens	se number	29	9d. Dete signed	(Month, D	Pay, Year)	
	> aull	llury	1)	DO	0353	17	1/8	RL)0/	
)	30. Name and address of person who co	ompleted cause of dee	oth (Item 23a) (Type, 5/00/	Print) WPH W	Ay, S	DITLAN	10,00	se	Muz	
State istrar	31. Date filed (Month, Dey, Yeer) JAN 1 6 2001	32. Registrar	s Signeture							



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43602

			Cei	rtificate of	Death		Reg. No.		
	1. Decedent's Name (First, Middla, L	ast)						Vaer	3. Time of Death
Physician	Betty Barry Si	nger							7:02 PM
/Medical Examiner	4e Facility Neme (If not institution, g				4b. City, Tow	m, or Location of Dea			
Examine	18055 River Roa	d			Tall 1	Timbers	St. M	arv's	
			s. last birthdey)	If Under 1 Yes	ar If Under 2			4	ce (Stete or Foraign
Funeral	049-14-9351	1 □ M 2 □XF	74 Yrs.	Months Day	s Hours	Min. (Month, I	Dey, Year)	Countr	
Director	Usual Residence of Decedent		/ 4			valuat	Acte of Death Month Day Year accember 31, 2000 7:02 In of Death 4c. County of Death St. Mary's Sete of Birth St. Mary's Interest of Birth, Day, Year) 9. Birthplace (Stete or Country) Interest of Birthplace	CLICUI.	
pur B	10a. State 10b. County	10c. (City, Town or Lo	ocation				10	d. Inside City Limits
72 hours after death with the Maryland natural, or items 23s or 28s-1 show deal Examiner must be notified at seed by Funeral Director	Managara Ch. Ma		n_11 m:	ala a see			Death Day Year 31, 2000 7:02 1 7:02 1	1 ☐ Yes 2 ☒ No	
the M	Maryland St. Ma	ry's	Call Tir					31, 2000 7:02 F 4c. County of Death St. Mary's ear) 9. Birthplace (State or Forecountry) 0, 1920 Connecticut 10d. Inside City L 1 Yes 25 Citizen of What Country? J. S. A. 14. Race - American Indian, Black, White, etc. Specify: White b. Kind of Business/Industry Health Care idan Sumama) 100 City or Town, Stata, Zip Code) Cyland 20690 c. Location - City or Town, State cantico, Virginia Home, P. A. Approximate Interval Between Onset and Death? Approximate Interval Between Onset and Death? 24b. Were autopsy find available prior to complete interval Between Onset and Death? 24b. Were autopsy find available prior to complete interval Between Onset and Death? 24b. Were autopsy find available prior to complete interval Between Onset and Death? 24b. Were autopsy find available prior to complete interval Between Onset and Death? 24b. Were autopsy find available prior to complete interval Between Onset and Death? 24b. Were autopsy find available prior to complete interval Between Onset and Death? 24b. Were autopsy find available prior to complete interval Between Onset and Death? 24b. Were autopsy find available prior to complete interval Between Onset and Death?	
or 28a-f or Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V		y7
th w	18055 River Road			2069	0		U.S.A.		
fier death v	11. Meritel Status	12. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No	U,S. 13.	Was Decedent of	Hispenic Ong	in? (Specify Yes or N Puerto Rican, etc.)	14. Rac		
T. T.		1 X Yes 2 No				Tuesto Filoari, etc.,			
b E	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Detes:		1□Yes ŽÇN	o Specify:		Specify	Year 2000 7:02 Foounty of Death Mary's 9. Birthplace (State or Fore Country) 926 Carrecticut 10d. Inside City L 1 Yes 25 on of What Country? A. Brace - American Indian, Black, White, etc. Specify: White of Business/Industry Lth Care umama) 1 Town, Stata, Zip Code) and 20690 and 20690 and 20690 and 20650 Approximate Interval Between Onset and Death P.A. yland 20650	te
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ygiene. nr tha matur nt, the Madell	(Specify only highast g	rade completed)	(Giva	kind of work don DO NOT use reti	ra during most ired)	of working		24b. Were autopsy find avoing between the country of Death Mary's 9. Birthplace (State or F. Country) 10d. Inside City II 1	
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and Men le marke aumatic	19a. Informant's Name/Relationship	(Type, Print)						nty of Death Mary's 9. Birthplace (Stete or Country) Connecticut 10d. Inside City 1	
127 T	Warren A. Singer	(Spouse)	P.O.	. Box 59	, Tall	Timbers,	Maryland	Year 2000 7:02 The of Death Mary's 9. Birthplace (Stete or Country) Connecticut 10d. Inside City 1 Yes 2 of What Country? In Care Business/Industry The Care The office of the Care The offi	0
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Departm Importar eny injur	21. Signature of Funeral Service Lio	1 -11	/ Ma	2. Name and Add	v-Gardi	ner Funer	al Home.	P.A.	
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	23a. Part1. Enter the disease, of conshock, or heart failure. List only	mplications that coused the d	Do not en	ter the mode of d	lying, such as o	cerdiac or respiretory	arrest,	110	Approximete
Physician	snock, or heart failure. List onl	y one cause on eech line.				4			Onset end Death
/Medical	Immediete Cause (Final	10-	0 - 0	0	F	- 11 . 1	A		On ex
Examiner	disease or condition resulting in death)	· care	uga	ummy	ey V	accur	2	, 0	xeeys !
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E X	Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury		- 4	/	1			1.4	
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been signed by the attentional be detached for un	Pert II. Other eignificant conditione	contributing to death but not r	esulting in the u	inderlying cause	given in Part I.	23b. Di	d tobacco use co	ntribute to	the cause of death'
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has by pe 2 s		10,8		1				of d	leath?
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i o o	25. Was cese referred to medicel			1	26. Place	of Death (Check on)	y one)		
direct	examiner?	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Other			24b. Were autopsy find available prior to completion of cau of death? 1 1 Yes 2 N	d
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is after death. I Director: After the in by the funeral Certification:	2 Accident investigati				Yes 2 N			24b. Were autopsy findi available prior to completion of caus of death? 10 Yes 20 No Other (Specify) courred I manner as stated. ce, and due to the cause(s)	
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To the Funerel D completely filled i Medical Ce	(Check only 2 Medical Exi	aminer: On the basis of exami	nation end/or In	vestigation, in m	y opinion, deat	h occurred at the tim	e, date and plece,	contribute to the cause of contribute to the cau	the cause(s)
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Compl	29b. Signeture end title of certifier	/ // // ~	MAG	Sac. Fice	ense number	110	290. Date signe	u (Month, L	Jay, 10al)
	WAR	AUVIE	V	1	064	7/7	January	4. 2	001
()	30. Name and address of person who	completed cause of deeth /II	em 23e) (Type	Print)		1	January	11 2	
0		11			A 10	-17 0000	06		
	J. Patrick J 31. Date filed (Mogth, Day, Year)			HOTTAMOC	xu, Mar	yland 2063	00		
State	- S. LIPIG THEO (MORIO [ISV YOR!]	32. Registrer's Sig	mature						



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State of Maryland / Department of Health and Mental Hygiene 43603 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month 12 **Physician** 2000 0325AM Gail Irvine Wood /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner St. Mary's Hospital St. Mary's Leonardtown 5. Social Security Number If Undar 1 Yaar Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 136-30-3648 Yrs. Director September 17, 1938 New Jersey Usual Residence of Decedant 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or learns 23s or 28s-I show the Medical Examiner must be notified at 1 Yas 2 No St. Mary's California Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 44560 Redwood Lane 20619 USA Funeral 12. Was Dacedant Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No It Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14 Race - American Indian 11. Marital Status Black, Whita, atc. 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates: 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White À 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) School Teacher Board of Education years 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be should be nd Mental is marked Colville Irvine Ethelyn Virginia Prest Kenneth 2 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 19a. Intormant's Name/Relationship (Type, Print) 1 and 2 t 44560 Redwood Lane, California, Maryland 20619 Randall J. Wood (Son) Department of Health Important: If Item 27 Baltimore, 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 January 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8 Charles Memorial Gardens 5,2001 Leonardtown, Maryland 4 ☐ Donation 5 ☐ Othar (Specify 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 11 Edward N. Brinsfield, Jr. M00052 P.O. Box 279, Leonardtown, Maryland 20650 23a. Part1. Enter the disaasa, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final HUVES disease or condition rasulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner the attending physician and hed for use as the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence ot) Box 68760. Due to (or as a consequence ot) 23b. Did tobacco use contribute to the cause of death? P.0. this certificate has been signed by the rail director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the undarlying causa givan in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown The law requires that Division of Vital Records. à 24b. Ware autopsy findings available prior to complation of ceuse ot death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 1 Yes Physician: funeral director, Be 25. Was cese reterred to medicet 26. Placa of Death (Check only one) examiner? Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 30 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 as or Attendenth.

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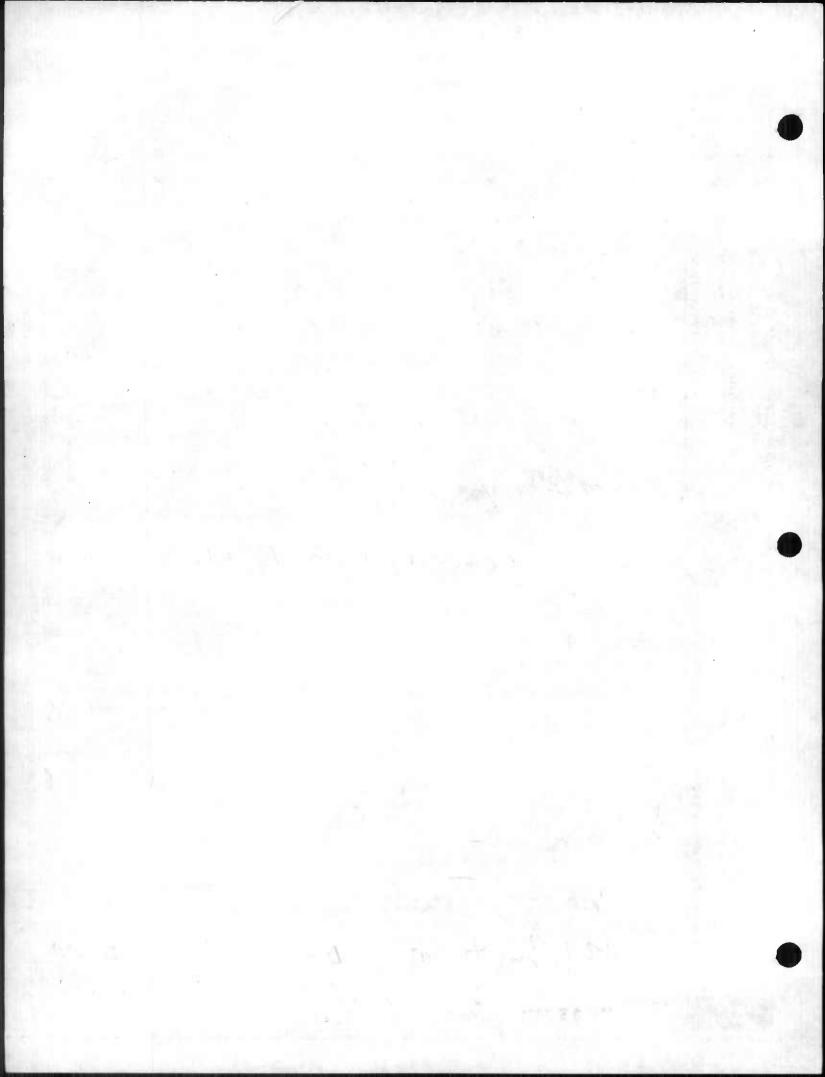
areal Director: After the filled in by the funer. 27. Manner of Death Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how Injury occurred Certification: Injury at Work? 1 Natural
Accident 5 Panding investigation 1 Yes 2 No 6 Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28a. Place of Injury - At homa, tarm, street, tactory, office building, etc. (Specify) 4 Homicida To the Hospital within 24 hours a To the Funeral D Hospital c 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.

2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and tale of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ,MD. 20650 WILLIAM BOYD II LEONARDTOWN DR.

State Registrar 31. Date filed (Month, Day, Year) JAN 05 2001

32. Registrar's Signature

Irene



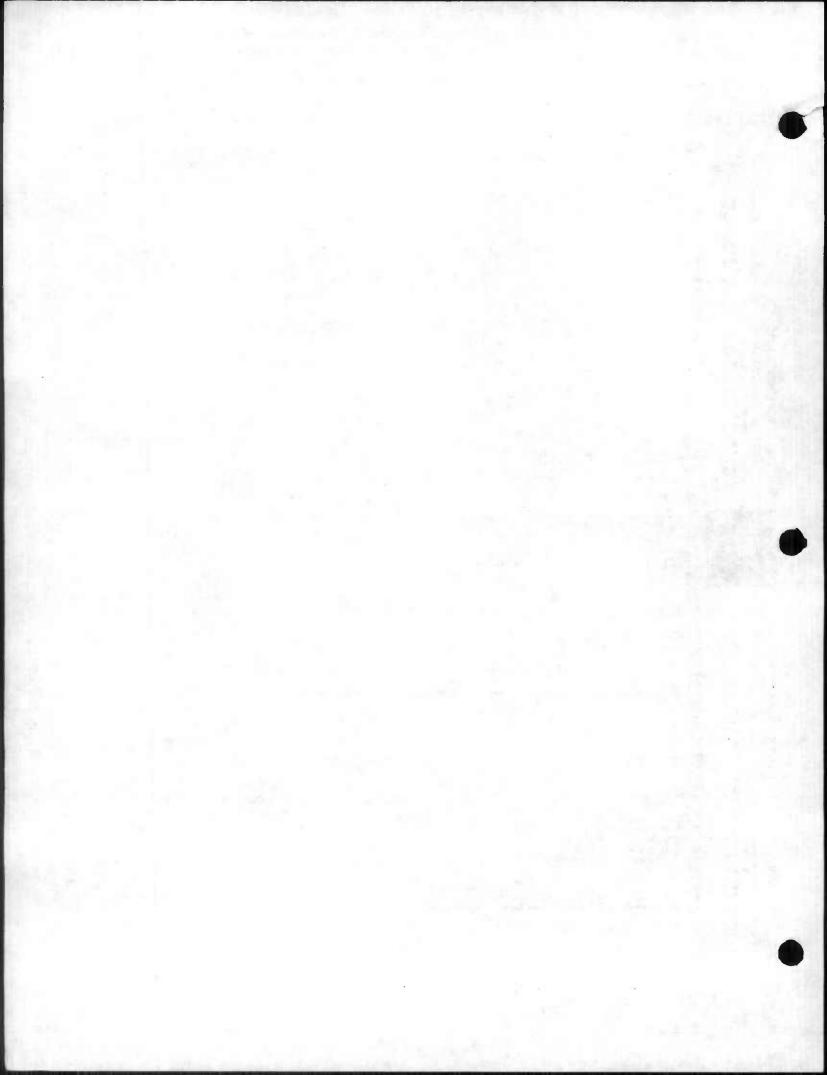
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend Items 19a,19b, per SA,G792,02/05/01dhb Oberarlment of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death DECEMBER 30, 200 913 **Physician** Gerald Francis /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 14,1935 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. Months Hours Michigan 369-34-0008 65 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b County 10c, City, Town or Location 1 Yes 2□No Director Baltimore r 28a-f a 10e. Street and Number 10f. Zio Code 10g, Citizen of What Country? Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Itema 23s or 2 my Injury or other traumatic event, the Mescal Exercises must be an once. 524 N. Charles Street #1307 21201 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 EYNo If Yes, Give Year or Detes: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Maritel Stetus 14 Never Married 2 Married 1 Yes 2 XNo Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Ö Bartender Beverage 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Evon M. Allord F. Godman Norman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) unk unk 301 St. Paul Street, Baltimore, MD 21201 Stella Maris Hospice 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility State Anatomy Board, 655 W. Baltimore Street Ronald S. Wade, Director per DVR Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 1 Month Kionein Examiner Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of) Division of Vitai Records, P.O. Box 68760, Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. the RELITOPATHO signed by t 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has page 1 Yes 20 No 1 ☐ Yes 2 ☐ No this certificate 26. Place of Death (Check only one STE//A MARIS AT MERC) Physician: 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6-Other (Specify) Hogpic E 1 Yes 2 No 10 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification: After or Attending 5 Pending investigation 1 Natural after death.

Director: After d in by the fur 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) in by 4 Homicide To the Hospital within 24 hours a To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier de ha derun auce 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST PAUL # 907 BACTILION 300 FVANCIS X. StrAin, ILI

State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 3 6 0 5

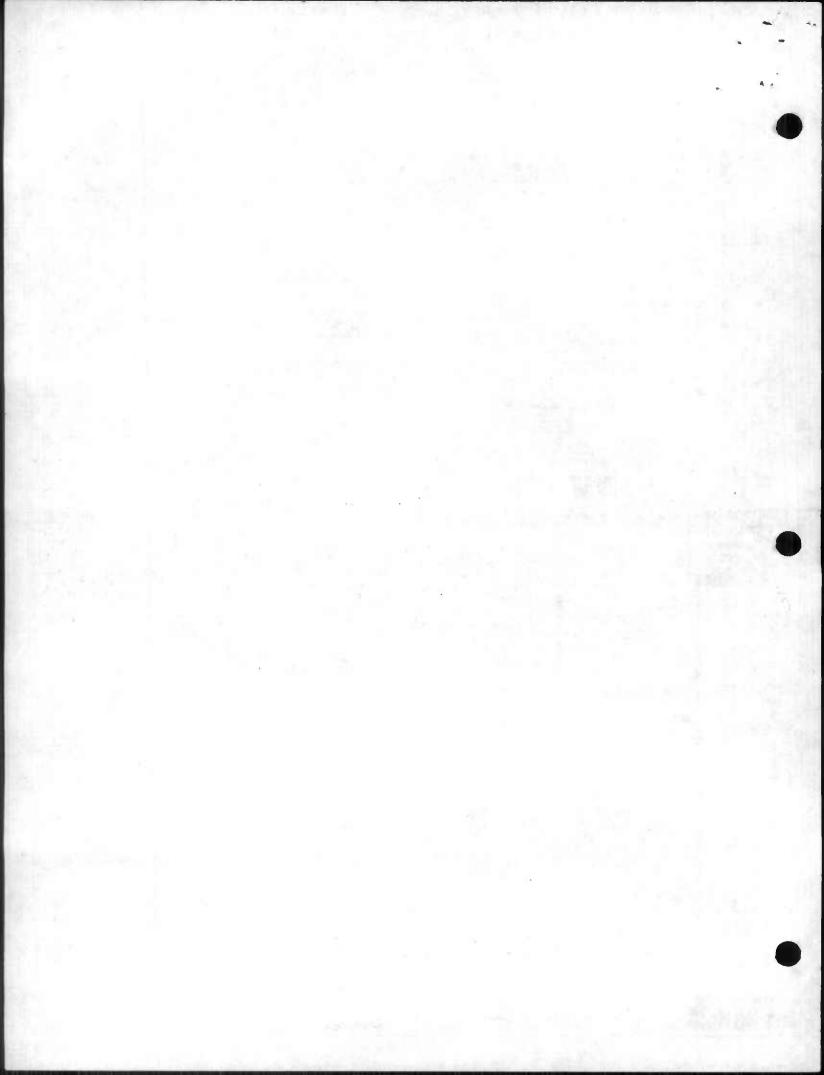
State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Beulah E. Bellamy 30, 2000 December 3:33 am /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Months Days 1□M 2☑F 237 58 4584 87 May 13, North Carolina Director Usual Residence of Decedent iled within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits x 28a-f show 1√ Yes 2 No Directo Maryland Prince George's Clinton 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Wedical Examiner must be 20735 USA 9211 Stuart Lane Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Merital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Merried 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: **Black** þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Service Worker Government 7th 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be 1 and 2 should be Health and Mentel Ellis Bellamy Melissa Galloway 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) permit. Peges 1 and 2 of Department of Health ar Important: If Item 27 le eny Injury or other treu Martha Davis/daughter 2719 Boones Lane Forestville, MD 20747 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01-06-01 Supply, North Carolina Galloway Cemetery 21. Signature of Funeral Service Licens 22. Name and Address of Fecility MARSHAll'S FUNERAL HOME OF MD 4308 Suitland Road Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. pproximate Interval Between Onset and Death Physician Immediate Cause (Finel disease or condition resulting In death) /Medical Examiner Examiner sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the bune Physician/Medicai Due to (or as a consequenca of): 80 080 for 23b. Did tobacco use contributs to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 2 No 3 Probably 4 Unknown 6 þ 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Was an autopsy page 2 should 2 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 10 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? Attending 1 Matural 5 Pending Investigation 1 TYes 2 No deeth. 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - Af home, farm, street, fectory, office building, etc. (Specify) 4 T Homicide Hospital or 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi edica (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 250 License number 30. Name and address of person who completed cause of deal (Item 23a) (Type, Print) Laxima Berwa, MD 9211 Stuart Lane Clinton, MD 20735

Registrar

31. Dafe filed (Month, Day, Year) JAN 1 6 2001 Registrar's Signature

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AMEND ITEM: #1 PER PHY G791 1-31-01 WR. Certificate of Death Amendment #1/11-15-00/WCHD/MAP 3. Time of Death 2. Deta of Death 1. Decedent's Nama (First, Middla, Last) Thomas Brendon Houlihan Month Day Year **Physician** BRENDON HOULTHAN 5.13 AH HOMAS 2000 NEVEMBER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, give street and number) Examiner Ba timore HODKINS Hospila he Johns Birthplace (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 12 M 20 F Yrs. 5/6/1934 Ireland Director 220-32-7971 Usual Rasidence of Decedent 66 the Marylend 10c. City, Town or Location 10d. Inside City Limits 10a. Stata 10b. County or 28a-f show the Medical Examiner must be notified at 1 Yas 2X No Salisbury Wicomico Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 USA 21801 1318 Toadvine Road Funeral death v Herra : 12. Wes Decedent Ever in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, 11. Meritel Status Bleck, Whita, atc. filed within 72 hours after 1 XYes 2 No If Yas, Giva Yeer or Detas: 1 Never Merried 2 Married ò Airforce 1 Yas 2 No Specify: Baltimore, Maryland 21215-0020 þ 3 Widowed 4 Divorced white "natural", Completed Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highest grade complated) 16b. Kind of Businass/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) manufacturing houses 12 Developer 17. Father's Nama (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) Be Peges 1 and 2 should be nent of Health end Mental marked Bridget Connolly Peter Paul Houlihan 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ratationship (Type, Print) permit. Peges 1 end 2 s Department of Health er Important: If Item 27 is any Injury or other trau once. .00 1318 Toadvine Rd., Salisbury, MD 21804 Hilda I. Houlihan (wife) 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 □ Donation 5 ☒ Other (Specify ntombment 11/6/00 Salisbury, Maryland Wicomico Memorial Park 22. Nama and Addrass of Facility
Holloway Funeral Home, P.A. 501 Snow Hill Rd., Salisbury, MD 21804 alune or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause of each line. 23a. Part1. Entar tha disease, or complications that shock, or heart failure. List only one cause of Approximata tntarvat Batween Onsat and Death **Physician** Immediata Causa (Finet disease or condition resulting in death) /Medical MULTIPLE MYELOMA 8 MONTHS Examiner Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of) and the death certificate be execu the burial-tre Box 68760 the attending physician Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yee 2 | No 3 | Probably 4 1 Unknown signed by The lew requires that þ Records, 8 24b. Ware autopsy tindings eveilabla prior to complation of causa of death? 24a. Was an autopsy performed? Be Completed funeral director, page 2 should this certificate has been 1 Yas 2 No 1 Tyas 2 No of Vital al or Attending Physicien: The safter death.

I Director: After this certificate of in by the funeral director, pa 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yas 2₽ No 28c. Injury at Work? Certification: 27. Mannar of Death 28b. Tima of 28d. Describe how injury occurred Division 1 Natural 5 Pending 2 🗌 No 1 Yas 2 Accident invastigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Ptaca of Injury - At home, farm, streat, factory, offica building, atc. (Specify) completely filled in by 4 Homicida To the Hospital e within 24 hours a To the Funerel D 1 Certifying Phyelcian: To the best of my knowledge, death occurred at tha tima, data and place, and due to the ceusa(s) and manner as stated.

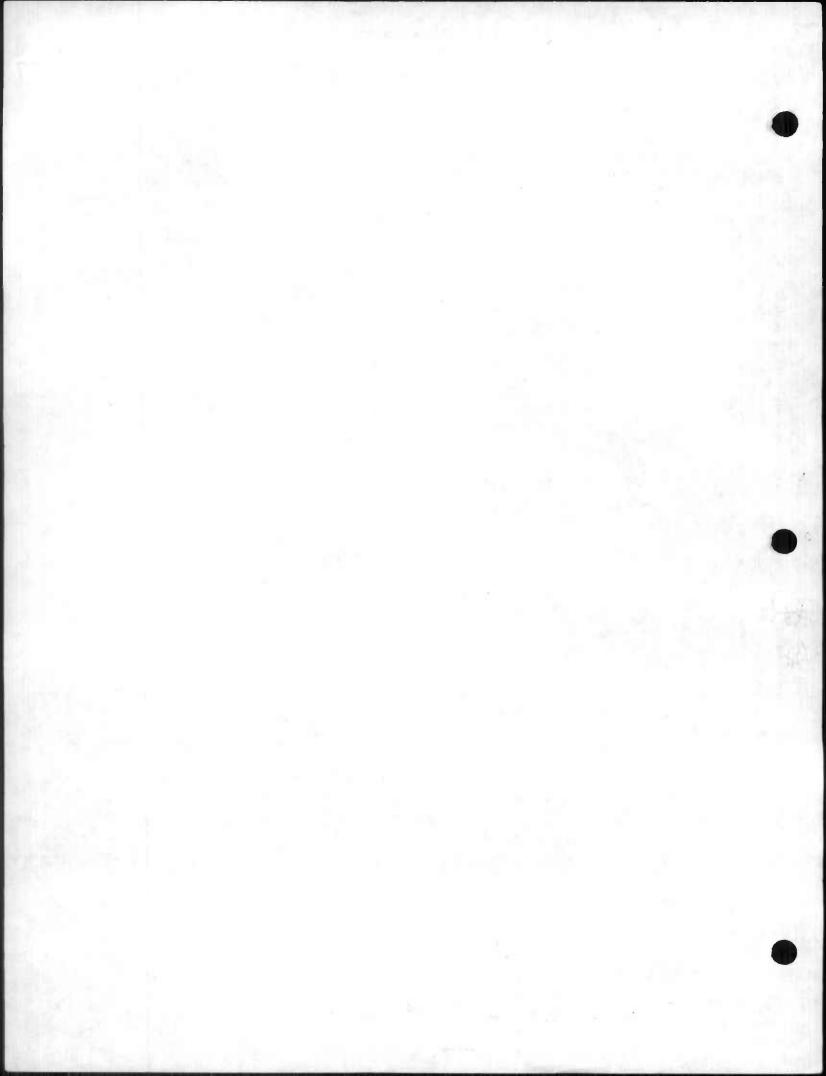
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29c. Licansa number 29d. Data signad (Month, Day, Year) 29b. Signatura and titla of cartifiar 10 mil RES-000 NOVEMBER Z, 2000 Kenneth clobuck MD VA 30. Nama end addrass of person who complated causa of death (Item 23a) (Type, Print) KENNETH BILCHICK, MD 600 N. WOLFESTKEET BALTIMORE, MD 21287 JOHNS HUP KINS HOSPITAL 31. Data filed (Month, Day, Year) legistrer's Signatura State NOV 0 8 2000 Registrar

DHMH 16 Rev 6/95

James 2 2000 3 10 1000

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 0 4 3 6 0 7

	EM: #23 PART I PER 1. Decedent's Neme (First, Middle, La:		OT OT CHEN	tilloale UI	Dealli	2. Data of Death			ima of Death
Physician	Dorothy Mae	Hine				Month Decembe	r 1,2000		5:50 AM
/Medical Examiner	4e Facility Name (If not institution, give	a street end number)			4b. City, Town, or Lo		4c. County of E		
Examiner	Washington Adven	tist Hospit	al		Takoma Pa	rk	Mont	gomery	7
Funeral Director	5. Social Security Number 6. S 577-60-5187	ax 7. Age ((In yrs. last birthdey) 90 Yrs.	If Under 1 Year Months Deys		8. Dete of Birth (Month, Dey, Jan. 31,	Year) 9. 1910 P	Birthplece (Country) ennsyl	Stete or Foreign Lvania
show day	Usuel Residence of Decedent 10a, State 10b, County	1	Oc. City, Town or Lo						side City Limits ☐ Yas 2 ☐ No
vith the Maryla t or 28a-f short be notified at	none none		Washingto				=10		1105 2 1100
€ % 5	10e. Street and Number 1841 Columbia Ro	ad,NW		10f. Zip Code 200	09	10	Og. Citizen of Wha USA	t Country?	
- P # 0		12. Was Decedent Ev Armed Forcas? 1 Yas 2 No If Yes, Give Yeer or Detes:		Wes Decedent of I If Yes, specify Cub 1 Yes 2 No	Hispanic Origin? (Spien, Mexicen, Puerto Specify:	ecify Yes or No- Rican, atc.)	Bleck, V	Amarican Ind Vhite, etc. white	lian,
Maryland 21215-0020 d 2 should be filed within 72 hours ef th and Mental Hyglene. 7 le marked other than "natural", or treumetic event, tre Medical Exam To Be Completed by F	15. Decedent's Ec (Specify only highest gre Elementery/Secondary (0-12)		(Give	DO NOT use retire	during most of work	ing	U.S. Go		
offled vent, m	17. Fathar's Nema (First, Middle, Last)	4			18. Mother's Name				
Maryland d 2 should be file h and Mental Hyr 7 le marked othe treumatic svent,						e Stoneb			
and le me	19a. fnforment's Neme/Reletionship (t end Number or Run		-	te, Zip Code)
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8 6 8 0	20e. Method of Disposition 1 Burial 2 Feremetion 3 4 Donetion 5 Other (Specific		20b. Place of Dispo cemetery, crea Metropoli	metory or other ple	D	ec.2,	ALexand		
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Box 68760 asth certificate be assecuted with the same attending physician and for use as the burial-transit clan/Medical Examiner	Immediate Ceuse (Final disaase or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediata ceuse. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Lest	b. AC SE.	RDIO PU ue to (or es e consei UTE RE) us to (or es e consei PSIS SYND) us to (or as a consei us to (or as a consei	quence of): ROME	NY ARR	EST			
death certification of for use a	Pert II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying cause o	iven in Pert I	23b. Dld to	bacco usa contri	bute to the	cause of death
that the ded by the detached	- HYPERTENDION	V Stage 3	7	indenying cause g	VOIT II T OIT I.	1 🗆 Yı	44	□ Probably	
If Records, P.O. Box The law requires that the death cert sate has been signed by the attending, page 2 should be detached for use a Completed by Physician/M	- Anaemia;	FRIAL	ITY, BI	LATERAL	PLEMALE	P 248. Wes ar perform		eveilable	utopsy findings e prior to ion of ceuse ?
Vital Red	- HYPOTHYROI	DISM, 1	HY POAU	SUMINE	MIA	1 □ Ye	s 2 No	1 ☐ Yes	2 No
Vital	25. Was case referred to medical				26. Plece of Deet	h (Check only on	е)		
T Sign	examiner? 1 Yes 2 No 27. Menner of Deeth 1 Neturei 5 Pending 2 Accident invastigetion		28b. Time o	of 28c. fnje	-		ence 6 Other ow injury occurred	(Specify)	
DIVISION Hospital or Attention 24 hours after death Funeral Director: stelly filled in by the dical Certifical	3 Suicide 6 Coufd not b determined		y - At home, ferm, st (Specify)	reet, factory, office		28f. Location (St. City or Town	reet end Number n, Stete)	or Rural Rou	te Number,
DIVISION C No Hospital or Attending P n 24 hours after death. No Funeral Director: After t pleiely filled in by the funeral edical Certification:		ysician: To the best of niner: On the basis of a end menner stets	xaminetion end/or in						
To the H. To the F. To the F. complete	29b. Signalura and title of cartifier	Sundu	, MO	29c. Licen	253367	29	9d. Dete signed (1	Month, Day,	Year)
	30. Name and address of person who	completed cause of dee	oth (Item 23a) (Type,	Print R;	Shyamsun SAPPER	Brung!	MD:	2087	6
State	31. Dete filed (Month, Dey, Year)	32. Registrer	a Signeture	1					



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State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death **Physician** Darlene Sue House 10, 2000 12:30 pm Dec. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8803 National Pike **Grantsville** Garrett 8. Date of Birth (Month, Day, Year) 11, 1949 If Under 24 Hrs. If Under 1 Year 5. Sociel Security Number 7. Age (In vrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Min. Days Hours Months 1 M 2 K 218-50-0752 51 Yrs. Maryland Director Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahba must be notified at 1 Yes 2 No Grantsville MD Garrett Directo "natural", or flams 23s or 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 8803 National Pike 21536 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Yaar or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. 1 Never Married 2 Married 1 ☐ Yas 2 ☐ No Specify: altimore. Maryland 21215-0020 Specify: White P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Food Service Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Cook Penn Alps Restaurant 12 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be peimit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is mark-2 should be it is and Mental it is marked of Garland O. Durst Roma Morrison 2 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e: Informent's Neme/Relationship (Type, Print) 8803 National Pike, Grantsville, MD Robert C. House, Husband 20b. Place of Disposition (Neme of 20c. Location - City or Town, State 20a. Method of Disposition cematery, cremetory or other plece) 1 XBurial 2 Cremation 3 Removal from State Grantsville Cemetery Dec. 12, 2000 Grantsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral/Service Licensee 22. Name and Address of Fecility Newman Funeral Homes, P.A., 179 Miller Street reman P. O. Box 275, Grantsville, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final IMMEDIATE CARDIOPULMONARY ARREST diseese or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner METASTATIC MALIGNANT MELANOMA 4 YEARS physician and the burial-transit Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting In death) Last Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): for use es Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. à t Yes 2 No 3 Probably 4 Unknown signed b Division of Vital Records. à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? peen has 1 Yes 2 No 1 ☐ Yes 2 No certificate director. 25. Was casa referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) 2 this 27. Menner of Deeth 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28b. Time of Certification: 28c. Injury et Work? 5 Pending Investigation 1 Netural or Attending after death.

Director: Aft
id in by the fur 1 TYes 2 TNo 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 24 hours aft Funeral Di letely filled in Hospital 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. To the Villin 2

State Registrar

29b. Signature and title of certifier

31. Data filed (Month, Day, Year) JAN 1 6 2001

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print)

Robin Bissell, M.D., 124 Miller Street, Grantsville, MD 32. Registrer's Signeture

29c. Licensa number D0034231 29d. Date signed (Month, Day, Year)

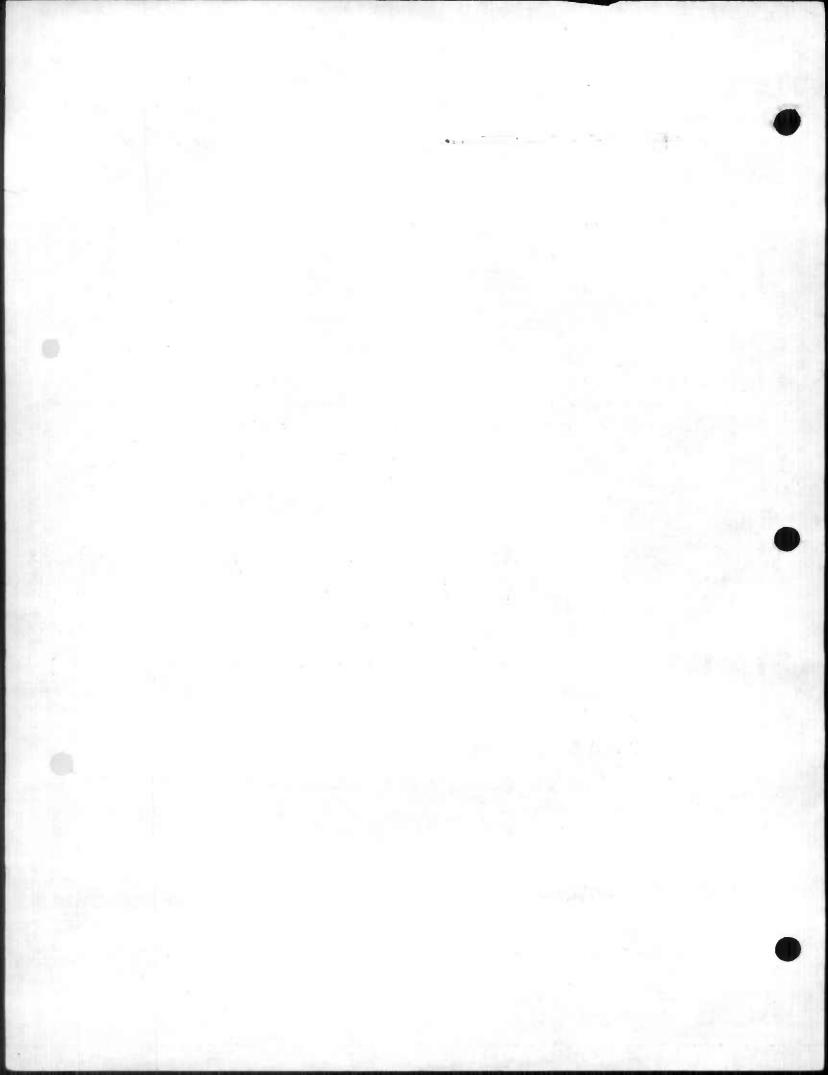
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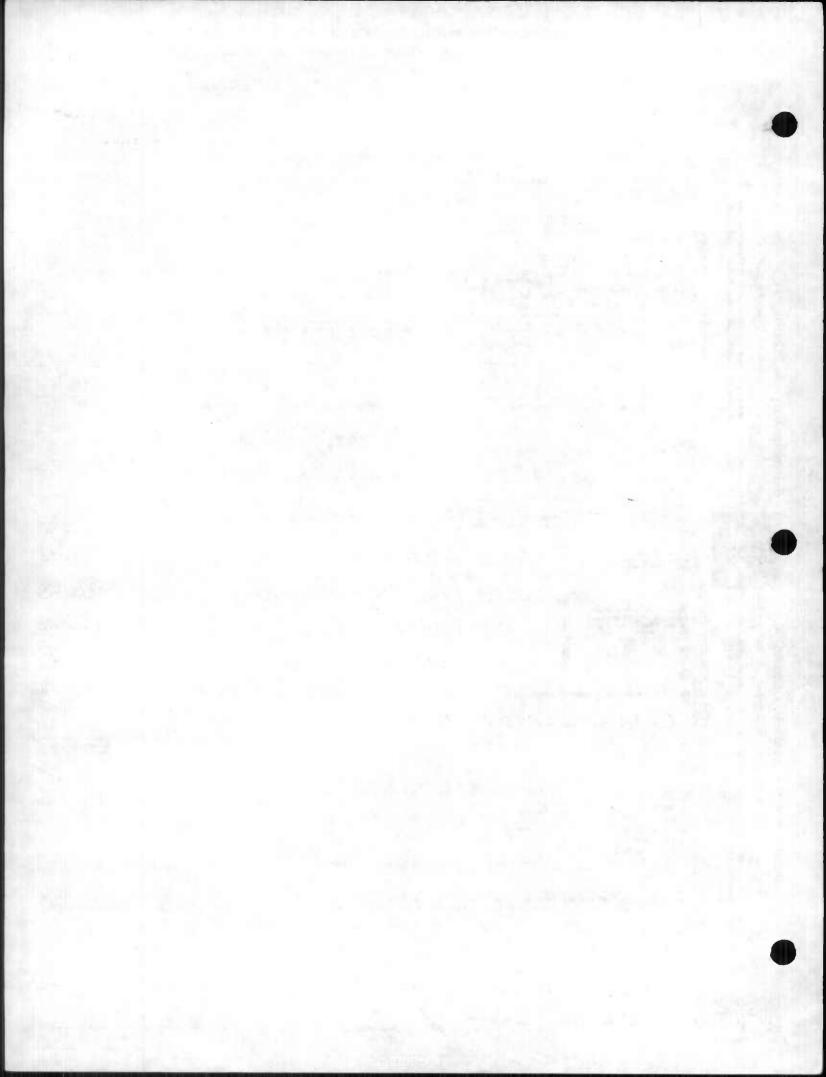
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ADMEND I	ITEMS: #28A=F PER MEO G793 2-15-01 WR. ADMEND ITEM: #27 PER 1	MEO G793 3-23-01 WR.
	Place Type or Print in Riack Indelible ink Accure All Co	onice Are Legible
Amended, I	TEM: 25 PER PHY G792 2-5-01 WP Maryland / Department of Health and Ment Item#4a, (per M.D)TCHD, 010201, sbb Certificate of Death	al Hygiene 0 0 4 3 6 0 9
	Oo.unouto of Dout.	Reg. No. ate of Death 3. Time of Death
Physici	sian Donald James Mc Laughlin	tonth Day Year 2000 10:23 P.M.
/Medic Examin	ner 4a Facility Nama (If not institution, giva street and number) St Marry S Hosp 4b. City, Town, or Location	
C II I	Sign mary 3 morning he mard	town St. Mary's
Funeral Director	5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) ff Under 1 Year If Under 24 Hrs. 8. D. Months Days Hours Min. JUI	ete of Birth (State or Foreign Country) Y 29, 1934 9. Birthplace (State or Foreign Country) MASS
	Usuel Residence of Decedent	
Aerylar Bhow	10a. Stata 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 ☐ Yes 3☐ No
death with the Menyland me 23e or 28e-f show	MD ST. MARYS MECHANICSVILLE 10e. Street and Number 10f. Zip Code	10g. Citizen of Whet Country?
th with		USA
	11. Marital Stetus 12. Wes Decedent Ever in U.S. Agmed Forces? 13. Wes Decedent of Hispanic Origin? (Specify \ If Yes, specify Cuban, Mexican, Puerto Rican	(es or No- , etc.) 14. Raca - American Indien, Black, White, etc.
020 urs aft, or l	1 Never Merried 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No Specify: 3 Widowed 4 No Divorced Year or Detes:	Specify: WHITE
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d 21215-0020 filed within 72 hours after tygliene. ther than "naturel; or he out, the Medical Essentien	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) 12 13. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) TEACHER	EDUCATION
be filed 2 tall Hygie dother word, to	17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First	t, Middle, Maiden Sumame)
Maryland d 2 should be file th and Mental Hy 7 le marked othe treumatic event	JAMES MCLAUGHLIN MARIE MCCA	ULEY
Mar 12 sho 16 m	19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Rou	
	MICHAEL MCLAUGHLIN/ SON 821 MARYLAND AVE #206 WAS 20a. Method of Disposition 20b. Place of Disposition (Name of December 2011)	
Pages lent of I hay or o	1XD Burial 2 Crametion 3 Removel from State 4 Donetion 5 Other (Specify) MD VETERANS CEMETERY 12-1	8-00 HURLOCK, MD
Baltimore, permit. Pages 1 er Department of Hea Important: if Hear 2 ery injury or other pince.	21. Signeture of Funeral Service Licensee	NEWNAM FUNERAL HOME PA
W 8258	200 S. HARRISON ST EAS	STON, MD 21601
Physician	23a. Pert1. Enter the disaesa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or resishock, or heart feilure. List only one cause on each line.	piretory errest, Approximeta Intervel Between Onset end Death
Physician /Medical	Immediate Ceuse (Finel	foretha 5 hours
Examiner	resulting in deeth) Due to (or es a consequence of):	Tai Cirgii = nonis
be is is	b. Cardiac ischemia	Diner 12 hours
'60, be assected sician and buriel-transit	Sequentially list conditions, if any, leeding to immadiate Cause Finer Underlying	La MEDICAL EXTRA 5 days
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Box 68760, death certificate be ave e attending physician and for use as the buriari	Cause (Disease or Injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): Caggulation Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert Atria fibrillation Cantulons Caggulation Caggulation Caggulation Caggulation Cantulons C	ader 7 days
Box Seath certif	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert	23b. Did tobacco use contribute to the cause of death?
Professional P.O.	Fig. 1. Street symmetric Conditions Controlling to Goal to the Conditions of the Con	1 Yes 2 No 3 Probably 4 Onknown
ds, F	a Trial fibrillation	Dab Mars a description
nbey v should	emphy jema	24a. Wes en eutopsy performed? 24b. Were autopsy findings evailable prior to completion of cause of death?
The law tie has bage 2 s	my 1 finte contuine Com 11	1 Yes 2 No 1 Yes 2 No
f Vital Bystelen: The Is certificate his director, page	25. Was case referred to medial 26. Place of Deeth (Ch	
0 4 57	Hospitel: 1 Impatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home	5 Residence 6 Other (Specify)
Affe Paris	28d. Injury at Work? 28d. Dete of Injury 28d. Time of UNIXIVOWN 1 Yes 2 No	Pescribe how injury occurred F'ETT.
Division or Attending after deeth. Director: After	3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)	ocation (Street and Number or Rural Route Number, ity or Town, Stele) 41681 QUEENS: LANDII
Diving after or after	HOME MEC	HANICSVILLE, MD.
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within To the	29b. Signature and title of certifier 29c. License number	29d. Dete signed (Month, Dey, Year)
	Leveldapollon MD D37874	December 13, 2000
	30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) St. Mary J Hospital Leonard	
Sta	24 Date Blad (Menth Day Vens)	Jool Juniyland
Registra		
DHMH 16 Rev 6/95	96	

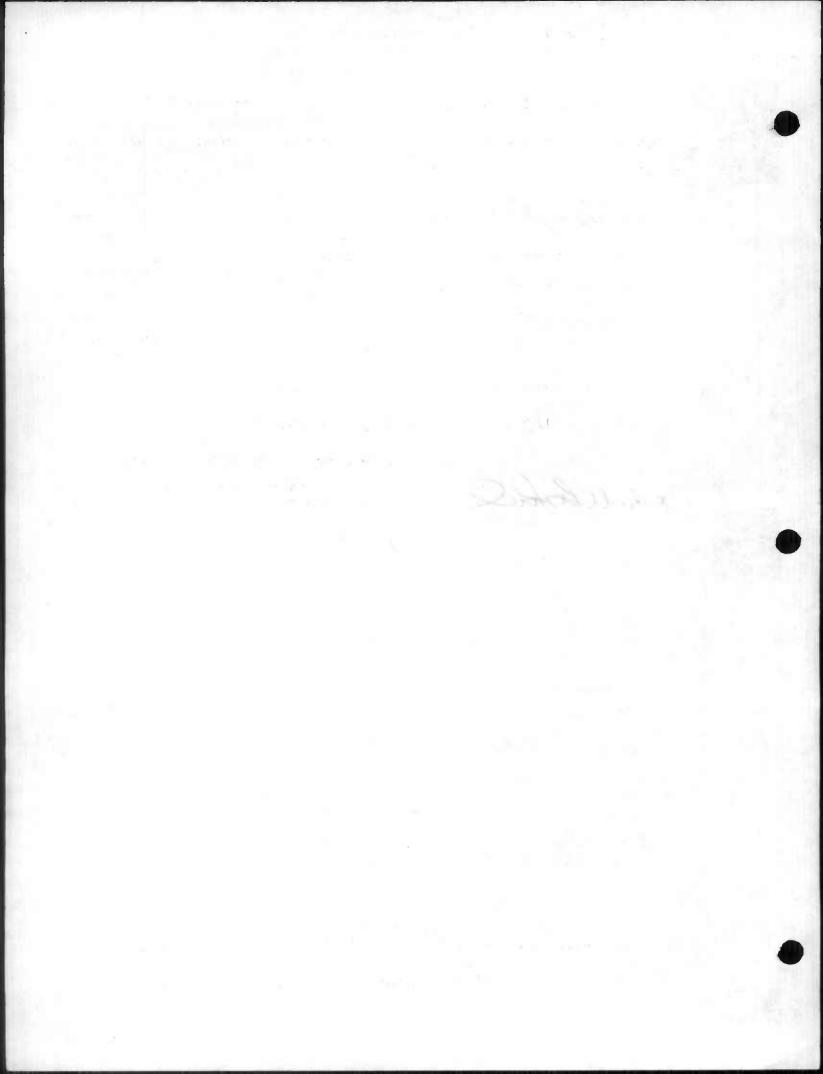


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/Medica	al	Helen		Roberts				4. Oh Tour and	Oct		000	8:05 PM
Examine	er 48	a Facility Name (If	f not institution,	, give street end num	ber)			4b. City, Town, or L	ocation of Deeti	4c. County o	DI Death	
		Genesis			The Pi		If Under 1 Yeer	Easto If Under 24 Hrs.	n A Data of Bird		lbot	
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The the	E	9	many to my	Conogo (1		Clan	n Shucker			Seafood	P1	ant
	11	7. Father's Name ((First, Middle, L	Last)				18. Mother's Nam	e (First, Middle,	Meiden Sumeme	9)	
	0	Walte	r	Robe	erts			Lottie		Ro	bert	S
N pur		9e. Informant's Na				19b. Mail	ing Address (Stree	t end Number or Rui	rel Route Numb	er, City or Town, S	State, Zip	Code)
27 ta 27		Sandra P	Pinder (Clift /Nie	ce	P.O.	Box 1766	, Easton,	Marylan	d 21601		
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Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU AMEND ITEM: 23 PER PHY G791 1-31-01 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3 Time of Deam Month Physician NOVEMBER 18, 2000 DENNIS TRVIN WICKHAM 4:40 AM /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** M DM 2DF Yrs 219-68-9952 43 Director October 18,1957 Maryland Usuel Residence of Decedent r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 □ No Maryland Frederick Frederick Directo 10e. Sfreet end Number 10f. Zip Code 10g. Citizen of What Country? 23a or the Medical Examiner must be 47 Apple Way 21703 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. or Items 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces' 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 Yes M No Specify: White à 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Painter Home Improvement 10 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental int: If Item 27 is marked or Margaret A. Hargett Harvey M. Toms 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5713 Mains Lane Frederick, MD 21704 Harvey M. Toms / Father 20b. Piace of Disposition (Name of 20c. Location - City or Town, Stete 20a. Method of Disposition important: If Its any Injure 1 Burial 2 Cremation 3 Removal from Sfete Resthaven Crematory 11/19/00 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitySkkot Cody (Licensed Mortician) 21. Signature of Funeral Service Licenses 44 Tremaine Ct. Baltimore, MD 21244 23a. Part1. Enter the disease, occomplications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RENAL FAILURE Physician /Medical Immediate Cause (Final 14000) Gen ort disease or condition resulting in death) Examiner Due to (or as a consequence of): Examine 6 000 YE TUSICT sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initieted events resulting In death) Last Due to (or as e consequenca of) Physician/Medical the Due to (or es e consequence of) 950 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 2 No 3 Probably 4 Unknown 1 ☐ Yes by 24b. Were autopsy findings available prior to 24e. Wes en eutopsy performed? Completed completion of cause of death? 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2

Division of Vital this tha funeral Certification: aftar death. filled in by or A aftar Hospital c 24 hours

Maryland 21215-0020

Baltimore,

1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, streef, factory, offica building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piaca, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stafed.

29c. License number

1214626

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title of certific

6

31. Date filed (Month, Day, Year)

Medical

Corusch 501 32. Registrar's Signature

Depera

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

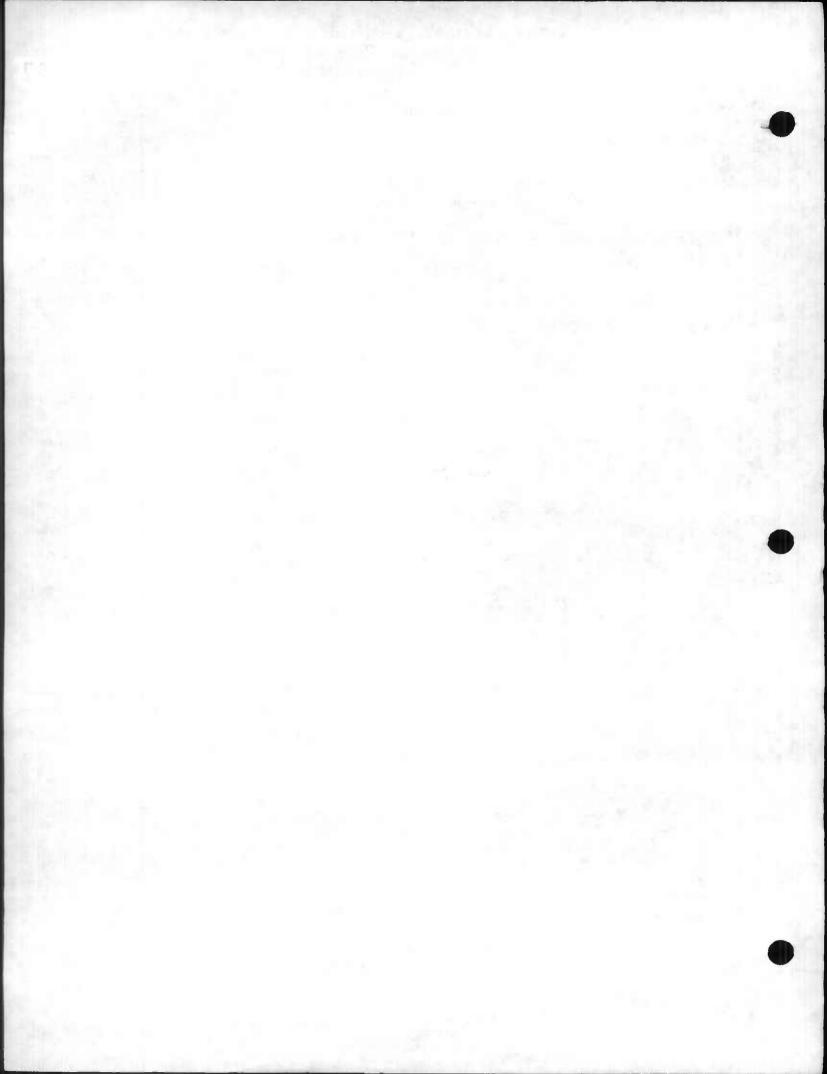
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Fredrois uns

29d. Dafe signed (Month, Day, Year)

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To the Within 2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene] [] Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Walcek 5:15 PM Joseph 067 2000 /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Daath Examiner Goodwi Home Menovite Grantsville Garrett If Undar 1 Year | If Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funerai** Months 12 M 2□ F Days Hours 041-20-2720 75 Director Sept 2, 1925 Connecticut Usual Rasidance of Dacedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Garrett 1 ☐ Yas 2 No Accident 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? death with 133 Claude Fike Road 21520 USA 12. Was Decedant Evar in U.S. Armed Forcas? 1 ⊠ Yas 2 □ No If Yas, Giva yaar or Datas: 1944–46 Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Navar Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: þ Specify: 3 Widowad 4 Divorced white Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry should be filed within 7; and Mental Hygiene. Elemantary/Sacondary (0-12) Collaga (1-4or 5+) neer Hewlett-Packard Corp.

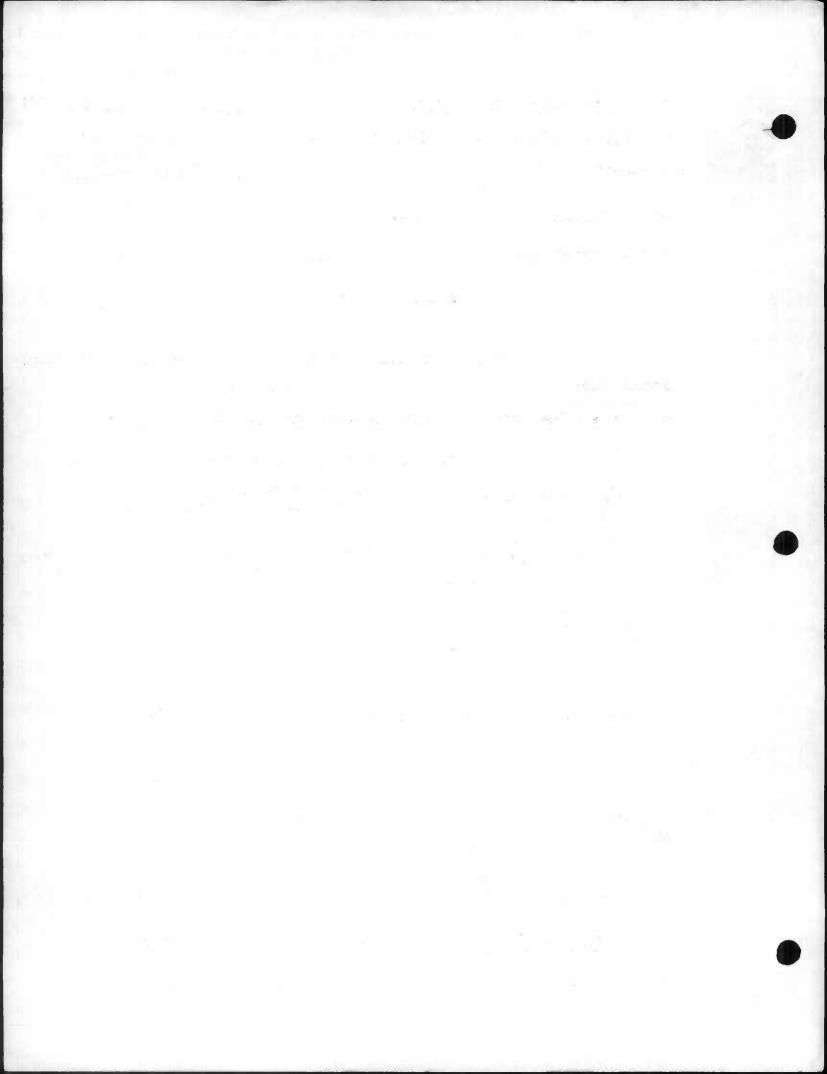
18. Mothar's Nama (First, Middla, Maiden Sumame) Electrical Engineer 4 yrs. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other any Injury or other traumatic event 17. Fether's Nema (First, Middle, Last) T is mark Michael Walcek Anna Macek 19a. tnformant's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code) Mary Louise Walcek/wife 133 Claude Fike Rd., Accident, MD 20b. Placa of Disposition (Nama of cematery, cramatory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burla! 2 ☑ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) Country Side Crem., Oct. 4, 2000 Davidsville, PA 21. Signatury of Funeral Service Lice 22. Name and Addrass of Facility Newman Funeral Homes, P.A., PO Box 275 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, A shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Physician /Medical Immadiata Causa (Final disaasa or condition rasulting in daath) rogressive Central Nervous System Degeneration Examiner Physician/Medical Examiner The law requires that the death certificate be executed physician end s the buriei-trens Sequantially list conditions, if any, laeding to immediata causa. Entar Undarlying Causa (Diseese or Injury thet initiated avents resulting in daath) Last Due to (or as a consaguance of) Box 68760 Dua to (or es a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the e 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P. 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown neuropothy by 24b. Wara autopsy findings availabla prior to completion of causa of daath? Completed 24a. Was an autopsy 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa referred to madical axeminar? Be 26. Placa of Daath (Check only ona) 1 Yas 2√No Other: 5 Rasidanca 6 Othar (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death Data of Injury (Month, Day Year) 28d. Describe how Injury occurred 28c. Injury et Work? or Attending P setter death.
I Director: After the funeral of In by the funeral Natural 5 Panding invastigation 1 Yas 2 No 6 Could not be determined 24 hours efter de le Funeral Directo pletely filled in by th 3 ☐ Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 4 Homicide 15 Cartifying Physician: To the best of my knowledge, death occurred et tha tima, date and place, and due to the ceuse(s) end menner es steted.
2 Madtcaf Examinar: On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to the causa(s) and mannar statad. 29a. Certifiar To the Hosp within 24 ho To the Fund completely f (Check only one) 29b. Signatura and titla of certifig 29c. Licansa number 29d. Data signad (Month, Day, Year) 30. Nama and address of parson who completed causa of daath (Itam 23a) (Type, Print) Accident MD 21520 PO BOX247 MD Walter K. Naumann

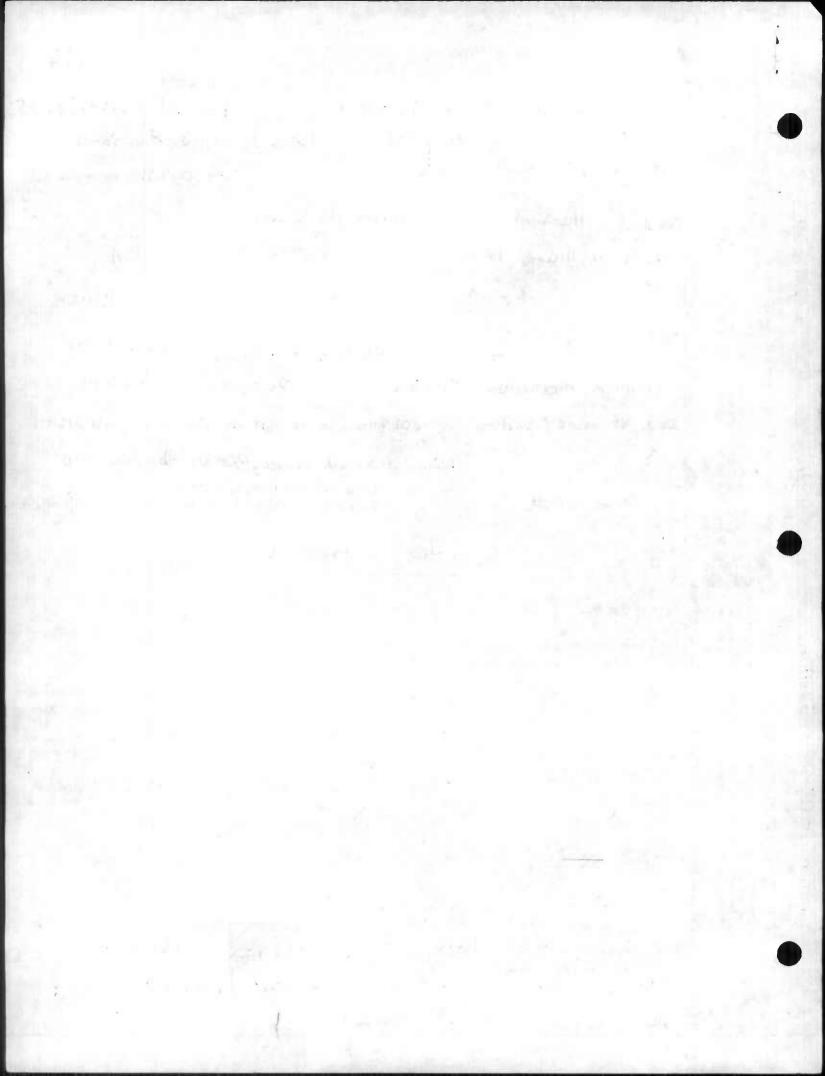
Registrar

31. Data filed (Month, Day, Year)

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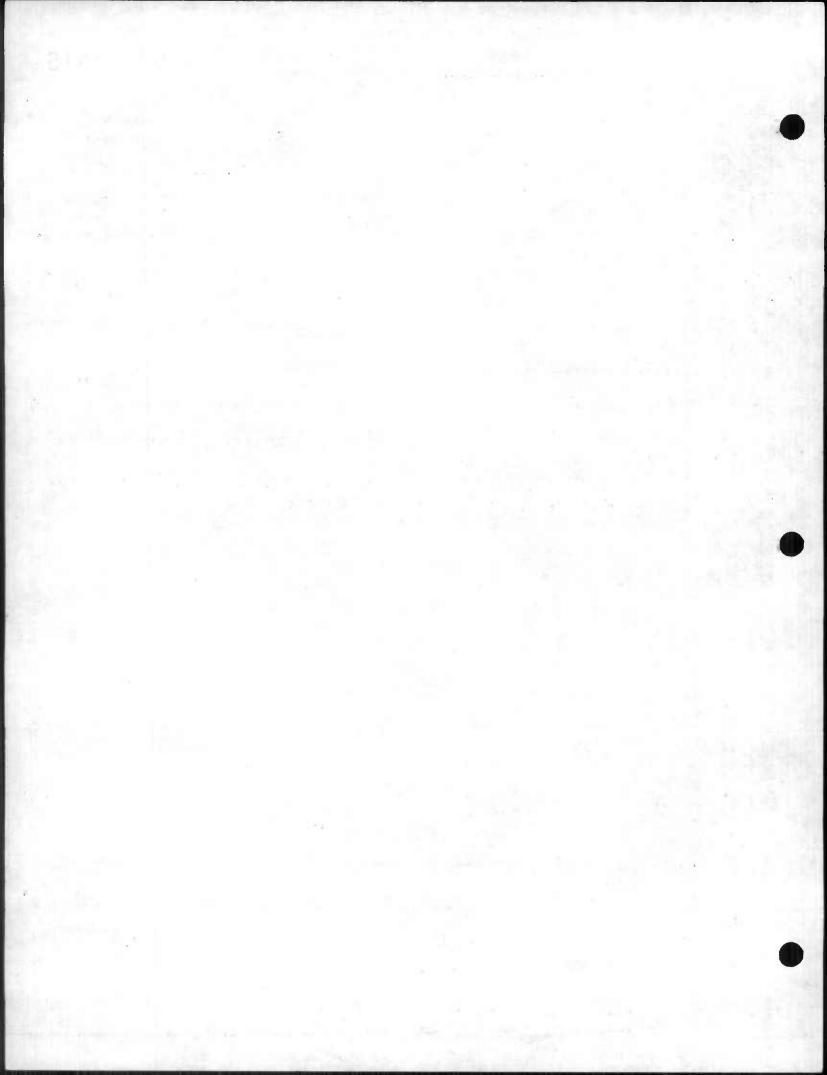
32. Ragistrar's Signatura





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Physician	Decedent's Name (First, Middle, La KWANG KIM	st)		tificate of		2. Date of De Month DECEMB	eth ER To, 2	3. Time of Death 5:20 PM	
/Medical Examiner	4a Facility Name (II not institution, git LAUREL REGIONA				4b. City, Town, or LAUREL	Location of Deat	of Death e Georges		
uneral irector	5. Social Security Number UTK 6.	Sex 7. Age (In y. 1	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Date of Birth 9. Birthplace (State of Country) b 15, 1937 Korea		
r show sed at	Usual Residence of Decedent 10a. State 10b. County MD Prince	Georges 10c.	City, Town or Lo	cation irel				10d. Inside City Limits 1 1 Yes 2 No	
at he notified if Director	10e. Street and Number 13913 Concord Av	enue		10f. Zip Code	.0707		10g. Citizen of V	Vhat Country? unk	
Examiner must by Funeral	11. Marital Status Unik 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cub I ☐ Yes 2\ No	lispenic Origin? (S an, Mexican, Puerl Specity:	pecity Yes or No o Rican, etc.)	Biac	e - American Indian, ik, White, etc. : Korean	
Completed	15. Decedent's E (Specify only highest gr Elementery/Secondery (0-12) unk		(Give	tent's Usual Occup kind of work done DO NOT use retire	during most of wo	rking unk	16b. Kind of Bu	unk unk	
o Be Co	17. Fether's Name (First, Middle, Last				18. Mother's Na	me (First, Middle	, Maiden Sumam	unk	
To	19a. Informant's Name/Relationship	Type, Print) unk	19b. Meilir	ng Address (Street	and Number or Re	ural Route Numb	er, City or Town,	State, Zip Code) unk	
m) or one	20a. Method of Disposition 1 Burial 2 Cremetion 3 4 Donation 5 Other (Special Control of Contr	Removal from State	p. Place of Dispo cemetery, crer	sition (Neme of natory or other ple	ce)	Date	20c. Location -	City or Town, State	
8000	21. Signature of Funeral Service Lice Renald S	Wade, Direct		Name and Address tate Ana	-	rd 655 201	W. Balt	imore Street	
be detached for use as the burial-transit by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieled events resulting in death) Lest	b. PULMONARY A	o (or es e consec RREST o (or es a consec o (or as e consec	juence of):					
by Physic	Part II. Other significant conditions	ons contributing to death but not resulting in the underlying cause give					tobacco uss co Yas 2□ No	ntributs to the cause of death? 3 Probably 4 Unknows	
Be Completed t						24a. Wes	en eutopsy ormed?	24b. Were autopsy findings svailable prior to completion of cause of death?	
director, page To Be Com	25. Was case referred to medical				26 Place of De	ath (Check only	Yes 2 XNo	1 Yes 2 No	
2	examiner? 1 ☐ Yes 2 ② No 27. Msnner of Death		ER/Outpatier	IL 3LI DON			idence 6 Oth		
To the Funeral Director: After this completely filled in by the funeral di Medical Certification: To	1 Netural 5 Pending 2 Accident investigation 3 Suicide 6 Could not to determined	OO Dian of lain. A	t home, farm, str	M 1	c. Injury at Work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Work? 1 □ Yes 2 □ No office 28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 Certifying Pl	nysician: To the best of my i	nowledge, deatl	n occurred at the ti	me, date and place	a, and due to the urred et the time,	cause(s) and me date and place,	anner es stated. and due to the cause(s)	
Мес	29b. Signature and the of certifier	and manner stated.	6	29c. Licens	se number			d (Month, Dey, Year)	
0	30. Neme and address of person who	completed seven of death (tom 22n) /Time	Drint)					



ROBERT R. Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. BERDAN 00-7521-041 State of Maryland / Department of Health and Mental Hygiene U amend item 28a-f per me G792 2/6/01 yf Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** DECEMBER 29, 2000 20:15 PM ROBERT RICHARD BERDAN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner EASTON TALBOT EASTON MEMORIAL HOSPITAL If Undar 1 Year | If Under 24 Hrs. 8. Dete of Birth MAY 19, 1981 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foraign Country) CO **Funeral** Hours Months Days 15 M 20 F 19 523-33-8981 Director Usual Rasidence of Decedent the Maryland 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location "natural", or items 23s or 28s-f show 1 ☐ Yes 2√7 No MD TALBOT EASTON Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9669B CORDOVA RD 21601 USA Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: if item 27 is marked other than "nature!", or items 23 ury or other traumstic event, the Medical Extension must Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐No If Yas, Giva Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Status Bleck, White, etc. 1 Never Merried 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collaga (1-4or 5+) PAINTER 12 HOME IMPROVEMENT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) RICHARD J. BERDAN PATRICIA A. NEWVINE 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19e. Informent's Neme/Relationship (Type, Print) 5982 MANADIER RD. EASTON, MD 21601 PATRICIA A. WOODSON/ MOTHER 20b. Plece of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition permit. Pages Department of Important: If it any injury or c pnce. 1 Burial 2 Cremation 3 Remove from Stete LANDING NECK CEMETERY 1-03-01 TRAPPE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL 200 S. HARRISON ST EASTON, MD 21601 Joseph M. Ostrowski HOME PA 23a. Pert1. Enter the disaese, or complications thet caused the death. Do not enter the mode of dying, such es cerdiec or respiratory arrast, shock, or heert failure. List only one cause on each lina. Approximata Intervel Between Onset and Deeth Physician Immediata Cause (Final disease or condition rasulting in daath) /Medical Multiple Examiner Due to (or as a consequence of) Physician/Medical Examiner attending physicien and for use es the buriel-trensit Sequentially list conditions, if any, leeding to immadiata cause. Enter Underlying Cause (Disaasa or Injury thet initieted events rasulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of): 98 23b. Did tobacco usa contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 1 Yaa 2 No 3 Probably 4 Unknown Ď Division of Vitai Records, 24b. Wera eutopsy findings available prior to 24e. Wes en eutopsy performed? Completed completion of ceuse hes is certificate he director, page 1 Tas 2 No Be 25. Was case referred to medical 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☑ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No P After this 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred pedestrian struck 27. Manner of Death 28b. Time of Injury Certification: Pending invastigation 28c. Injury et Work? P or Attending 1 Neturel by auto M 1 Yes 2 No 2 Accident 12/29/00 8:00 actor: / 6 Could not be detarmined 28f. Location (Street and Number or Rural Routa Number City or Town, State) Rt., 50 & Hiners La 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) Talbot Co., Maryland Hiners Lane 4 Homicide aftar 0 To the Hospital o within 24 hours at To the Funeral Di road 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the causa(s) and manner as stated. 29a. Cartifian edicai To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Chutem lennis 31. Dete filed (Month, Day, Year) JAN 0 2 2001

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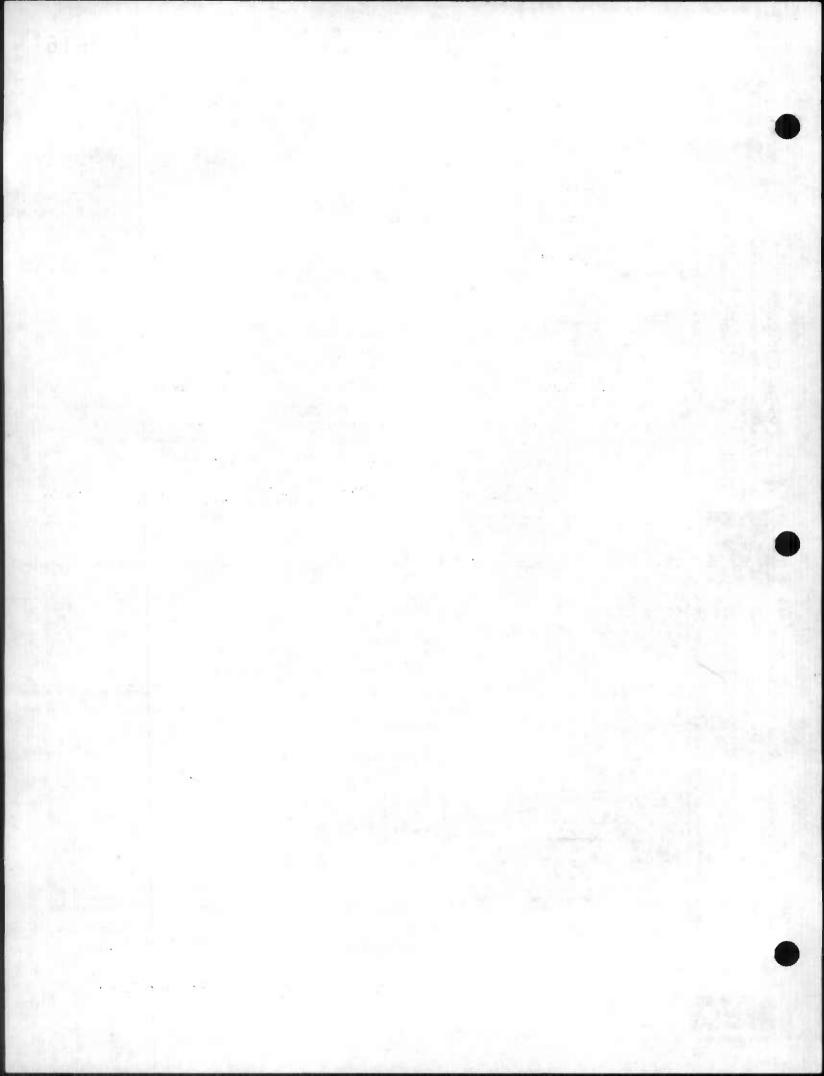
111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

2 Churto no

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCME

DECEMBER 30, 2000



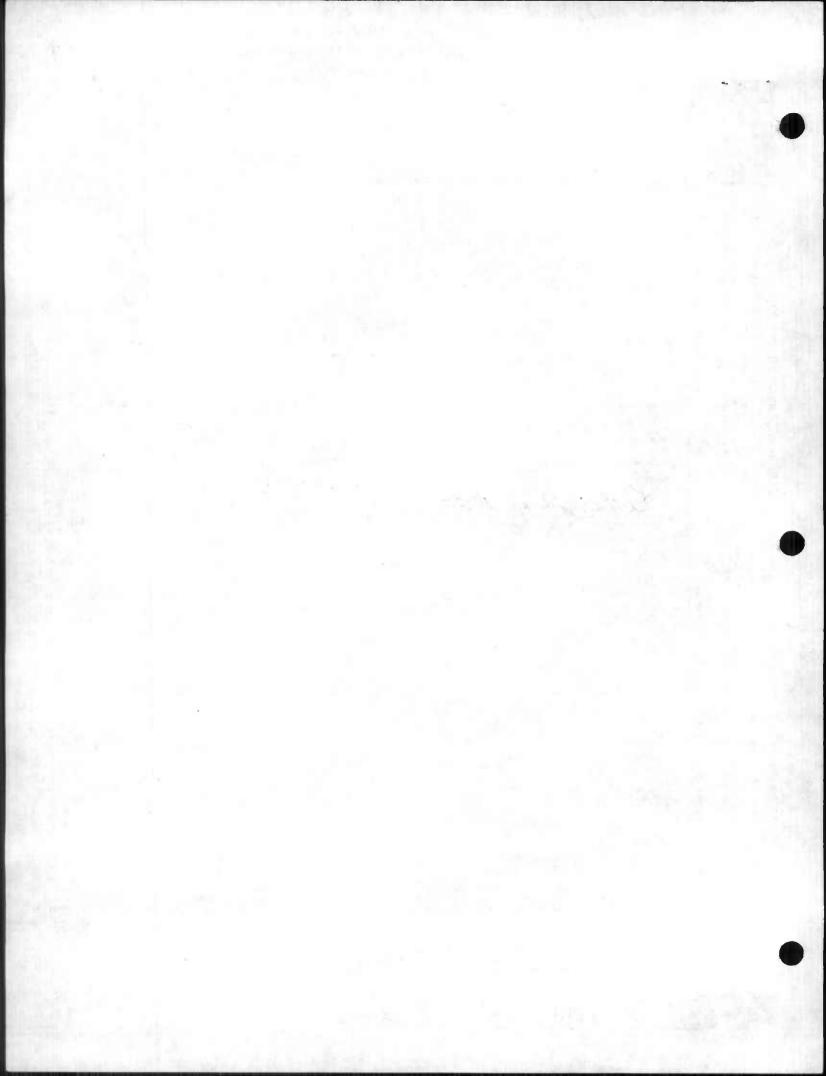
Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. ADMEND ITEM: #26 PER PHY G793 3-21-01 WR Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year December 28, 2000 **Physician** 10:55pm Annie Mae Edwards /Medical 4e Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4628 Lacy Ave. Suitland Prince George's If Under 1 Year | If Under 24 Hrs. 9. Birthplaca (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Feb. 17, 19(16 6. Sax **Funeral** Months Days Min 1□M 2 F Hours North Carolina 239-48-1819 84 Yrs. Director Usual Rasidance of Decedant the Maryland 10s State 10b County 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☐ No Directo District Heights Maryland Prince George's 10e. Streef and Number 10f. Zip Coda 10g. Citizen of What Country? in the Medical Examiner must be a 20747 United States 1935 Tanow P1. Funeral 72 hours after death 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2⊠ No If Yes, Giva Yaar or Datas: Race - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Marital Status 1 Nevar Married 2 Married Black. 1 ☐ Yes Z No Specify: þ 3€ Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) at Hygiene. Elementery/Secondary (0-12) Collega (1-4or 5+) Private 8th Homemaker permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oths any Injury or other traumatic event, phose. 18 Mother's Nama (First Middle Meiden Sumama) 17. Father's Nema (First, Middle, Last) Hattie Sutton Isom Joyner 19a. Informant's Name/Ralationship (Type, Print) 19b. Melling Addrass (Straat and Number or Rurel Routa Number, City or Town, State, Zip Code) 4628 Lacy Ave. Suitland, Maryland 20746 Jones / Daughter Alma 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Washington National Cem. 1/2/01 Suitland, Md. 22. Nama and Address of Facility
Alexander S. Pope Funeral Homes 21. Signature of Funaral Sarvice Licensae 101085 20747 5538 Marlboro Pike/Forestville, Md. 23a. Part1. Enter the disease or complications that caused the deeth. Do not anter the mode of dying, such as cardiec or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediata Causa (Finel disaasa or condition resulting in daeth) 3 yrs. Congestive Heart Failure Examiner Dua to (or as a consequence of): 5 yrs. Emphysema Examir Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or es e consequence of) Pert II. Other algrificant conditions contributing to death but not resulting in the underlying cause given in Pert II. 23b. Did tobacco use contributa to the cause of death? Ž B 1 Yea 2 No 3 Probably 4 Unknown by Division of Vital Records. 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed atte has page 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No DAUGHTER'S HOME 25. Was casa refarred to medical 26. Placa of Death (Check only ona) 88 Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No 2 1 28a. Data of Injury (Month, Day Year) 28b. Tima of 27. Manner of Death 28d. Dascribe how injury occurred 28c. Injury at Work? Certification: or Attending 5 Pending invastigation 1 Natural 1 Yas 2 No 2 Accident 3 Suicide 6 Could not be datermined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Pleca of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida Affec To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred et tha time, dete and plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, data and plece, and due to the cause(s) and manner stated. adical 29e. Certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) 29b. Signature end title of certifier D39691 January 2, 2001 30. Nama and addrass of person who completed cause of death (ftam 23a) (Type, Print) B. Redjaee, M.D. 4467 Old Branch Ave. #201 Temple Hills, Md. 20748

State

Registrar

31. Data filed (Month, Day, Year) 82. Registrar's Signeture JAN 1 6 200

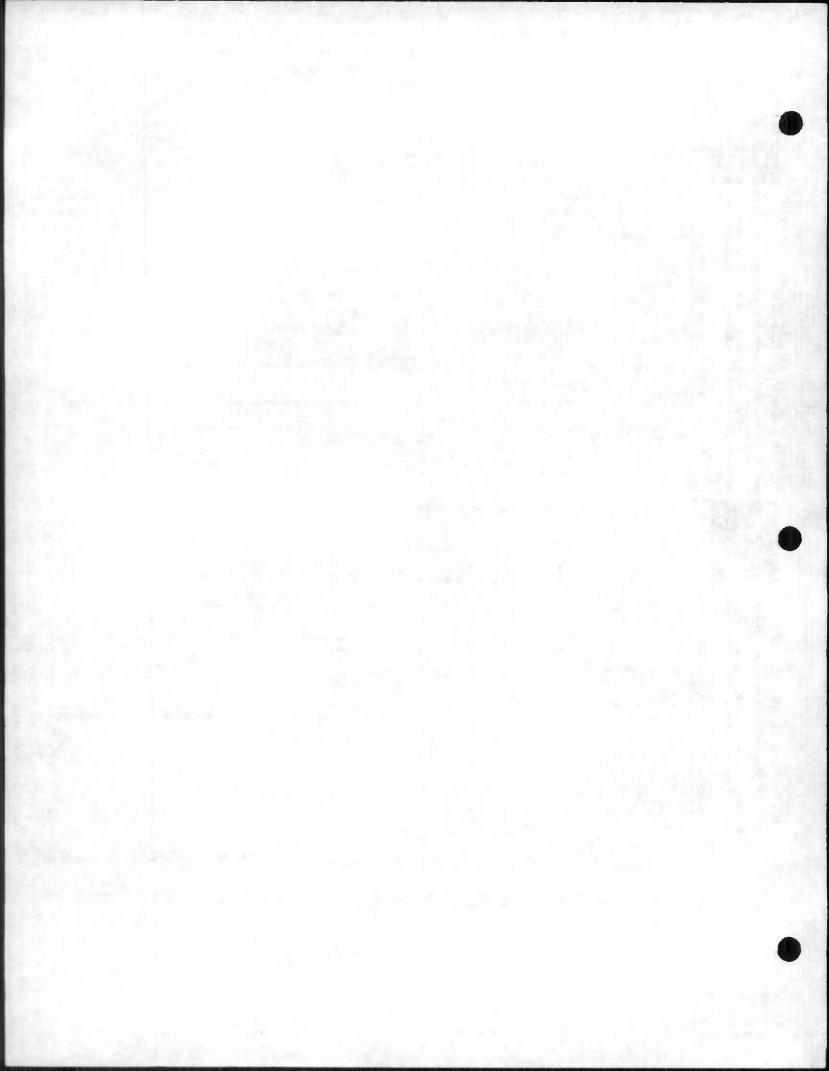


Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 23a,ptII, $\frac{1}{27}$ Rogistrar per me G792 1/22/01 yf Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** David Joseph Cronin December 3:57 PM 2000 4, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 5300 Riveria Drive Harford Joppa If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Dev. Year, Aug 11, 1959 Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** tEM 2□F 214-82-8467 41 Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Harford Joppatowne 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5300 Riveria Drive 21085 USA 238 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Bleck, White, etc. 11 Marital Status the Medical Examiner 1 Never Married 2 Married Specify: White 5 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. fireman City Government Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Robert Buxton Cronin Jeanne Cecelia McBurney 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) . Item 27 Robert E. Cronin - Brother 5306 Litany Lane, Baltimore, Maryland 21237 imore, 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 12 Burial 2 Cremation 3 Removal from State = 5 12/9/2000 Gardens of Faith Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Baltí 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee Holly McComas Pennington per DVR 1317 Cokesbury Road, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ATHEROSCLEROTIC CARDIOVASCULAR DISEASE /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury Due to (or as a consequence of): Examine certificate be executed and-trans. that initiated events resulting in death) Last Due to (or as a consequence of) ettending physicien a for use es the burial-Box 68760, Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal deeth 4 Pregnant at time of deeth 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the e 1 Yes 2 No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Dunknown DIABETES MELLITUS Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of ceuse of death?

1 ☑ Yes 2 □ No has ebed certificete 1X Yes 2 1 No Division of Vital Physicien: 25. Wes case referred to medical 8 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 8 DOther (Specify) at scene P 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury et Work? After the Hospital or Attending 1 Natural 5 Pending Injury death. 1 Yes 2 No investigation 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 2-15-01 OCME Chutzmo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis Chute 111 Penn Street Baltimore, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Neme (First, Middla, Last) 2. Dete of Death 3. Time of Death **Physician** /Medical 4b, City, Town, or Location of Death 4a Facility Nama (If not institution, give street end number 4c. County of Death Examiner ANNE ARUNDEL Hours Min. 8. Data of Birth Month, Day, If Under 1 Yaer 5. Social Security Number 7. Aga (In yrs. last birthday) 6. Sex **Funeral** Days 100 M 2□ F 578-50-5793 62 Director Usuel Residence of Dacedant the Manyland 10b. County 10a. Stata 10c. City, Town or Location 10d. Inside City Limits item 27 le marked other than "naturel", or itema 23a or 28a-f show other treumstic svent, the Wed cell Examinar must be notified at 1 Yas 2 No WASHINGTON Director NONE 10e. Street and Number 10f. Zlp Coda 10g. Citizen of What Country? 1604 MONTELLO AVE N.E 20002 U.J.A Funeral Mc Knight, Emest 72 hours after death 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Meritel Stetus TYAS 2 No KYes, Giva Yeer or Dates: 1 Naver Married 2 Married 1□ Yas 2X No Specify: BIACK Specify: by 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry I Hyglene. Elementary/Secondary (0-12) Collega (1-4or 5+) CONSTRUCTION permit. Pages 1 and 2 should be filed will Department of Health and Mental Hyglen Important: If item 27 is marked other the eny injury or other treumatic avent, the PORGS. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be LUCILE ERNEST N. MCKNIGHT 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 3006 BROOK HAVEN CT. OXON HILL, MD 20793 EUGENE MCKNIGHT BRBINER 20c. Location - City or Town, Stata
TRIANGE, VA 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 1 ■ Burial 2 □ Cremation 3 □ Ramoval from Stata QUANTICO NATI 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Service Licensea 22. Nama and Addrass of Facility 908 KENNEDY ST. N. W. WASh. D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset end Death **Physician** /Medical Immediata Causa (Final Sepsis days disaasa or condition rasulting in death) Examiner Examiner attending physician and for usa as the burial-transit The lew requires that the death certificate be asscuted Sequentially list conditions, if eny, leading to immadiata causa. Entar Undarlying Cause (Disease or injury that initiated evants rasulting in death) Last Dua to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or es e consequence of): signed by the a d be detached f Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 I Inknown þ 24b. Wara autopsy findings evailable prior to 24a. Was an autopsy performed? Completed completion of causa of death? certificeta has b 1 Yes 2 No Physicisn: 25. Was casa rafarred to medical examiner? 8 26. Placa of Death (Check only ona) Hospital: Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 10 1 Yes 20 No 1 Inpatiant 2 ER/Outpatient 3 DOA this Director: After the 27. Mannar of Death 28a. Date of injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 DNatural 5 Panding investigation 1 Yas 2 No 2 Accident 6 Could not be datamined 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, afc. (Specify) 4 Thomicida within 24 hours at To the Funeral Di 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifiar (Check only 29b. Signature and title of certife 29c. License number 29d. Date signed (Month, Day, Year) 50725 30. Nama and address of person who completed causa of death (Item 23a) (Type, Print) Hole Swerna el 31. Data filed (Month, Day, Yeer) 32. Registrer's Signatura State

ORIGINAL

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Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend item# 1 HCHD 12/27/00 BRH 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Harold Francis Bishop Month Year **Physician** HAROLD 1730 BISHOP-2000 DECEMBER 21 /Medical 4e Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** Months Days Hours 1 M 2 F 59 711-03-2364 SETTEMBER 5 1941 Maine Director Usual Residence of Decedent 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits Nerne 23e or 28a-f short ner must be notified at 1 ☐ Yas 2 ☐XNo Maryland Directo Harford Edgewood 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 306 Crestwood Drive 21040 USA Funeral 12. Wes Decedant Evar in U.S. Armed Forcas? 1 ½ Yas 2 □ No 1962 — If Yes, Give Yaar or Datas: 1984 Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. 11. Merital Status Black, White, etc. 1 Nevar Merried 2 Married Specify: White 1 ☐ Yas 2 ☑ No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation
(Give kind of work dona during most of working 16b. Kind of Businass/Industry Wheel & Track Automotive Elementary/Secondary (0-12) Collega (1-4or 5+) U.S. Government 12 Training Instructor permit Pages 1 and 2 should be file.
Department of Health and Mercal Health and Mercal Health and Mercal Health and Just or other any liquity or other. 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) ag Harold Francis Bishop, Sr. Stella (u/k) Daigle 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Anita C. Bishop-Wife 306 Crestwood Drive, Edgewood, Maryland 21040 20b. Place of Disposition (Nama of cematary, cramatory or other plece) 20c. Location - City or Town, Steta 20a. Method of Disposition 1X Buriel 2 Crametion 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) St. George's Episcopal 12/27/00 Perryman, Maryland 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility McComas Funeral Home, P.A. Much 23a. Parff. Enter the disease, or completellors that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest,
Shock, or heart failure. List only one cause on each line.

1317 Cokesbury Road, Abingdon, Maryland 21009
Approximete
Interval Between
Onset end Death Intarval Between Onset end Death **Physician** Immediata Causa (Final disaasa or condition resulting in daath) /Medical SEPSIC STNDROME days Examiner Dua to (or as a consequenca of): Examiner CHOLECYSTITES Sequentially list conditions, if any, leading to immediata causa. Entar Undarlying Cause (Disease or Injury that initiated evants rasulting in death) Last Due to (or es a consequence of): mkum PULMONARY EMBOLUS Physician/Medical Dua to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Non-small cell LUNG CANCER b 24b. Ware autopsy findings available prior to completion of cause of deeth? Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 Yas 2 No 25. Was case refarred to medical axaminar? Be 26. Plece of Deeth (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) P 1 Yas 200 No 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how Injury occurred 28b. Tima of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 □ Yes 2 □ No Invastigation 2 Accidant 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Pleca of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida

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15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner steted. 29b. Signature and titla of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year)

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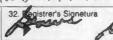
DECEMBER 21 2000

30. Name and addrass of person who complated cause of deeth (Item 23a) (Type, Print) mo DAVID ORRIN MARTEN

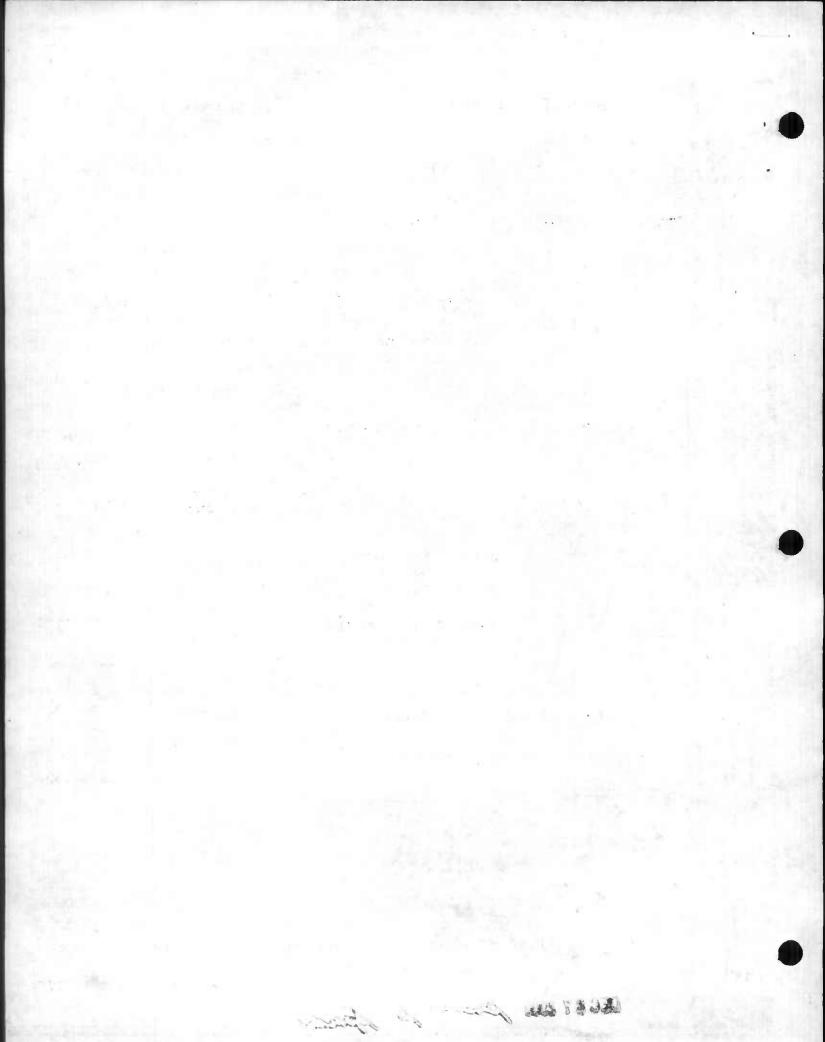
4940 Eastern Ave., Baltimore, MD 21224

State Registra

(Check only one)







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend item 23a per md G792 2/7/01 yf

State of Maryland / Department of Health and Me	ental Hygiene 00 4362	1
Certificate of Death	Reg. No.	

Physician /Medical Examiner

> Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or itama 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

MYRON CAUSEY JR.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be associted within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 687

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md G792 2/7/01 yf		C	ertifica	HE UI	Dealli			Reg. No.			
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Salisbury Center;	Genesis Elde	erCare		100	Salis	sbury	y, Md.	W	COM	ico	
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Usuel Residence of Decedent	100	. City, Town or	- 1 mastice							104	Include City I imit
10a. Stete 10b. County											Inside City Limit XI ☐ Yes 2 ☐ No
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Joan E. Causey/Wi			_								21804
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21. Signifiting of Pineral Service Licens	to also as	-	Hollo	way	ess of Fecili Funer	al H	ome Pro	ofessi	onal	Asso	ociation
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Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	Due to	MULTI-	SYSTEM Requence of	ATROP	ng, such es				WD 2.	At Int Or	tervel Between nset end Death
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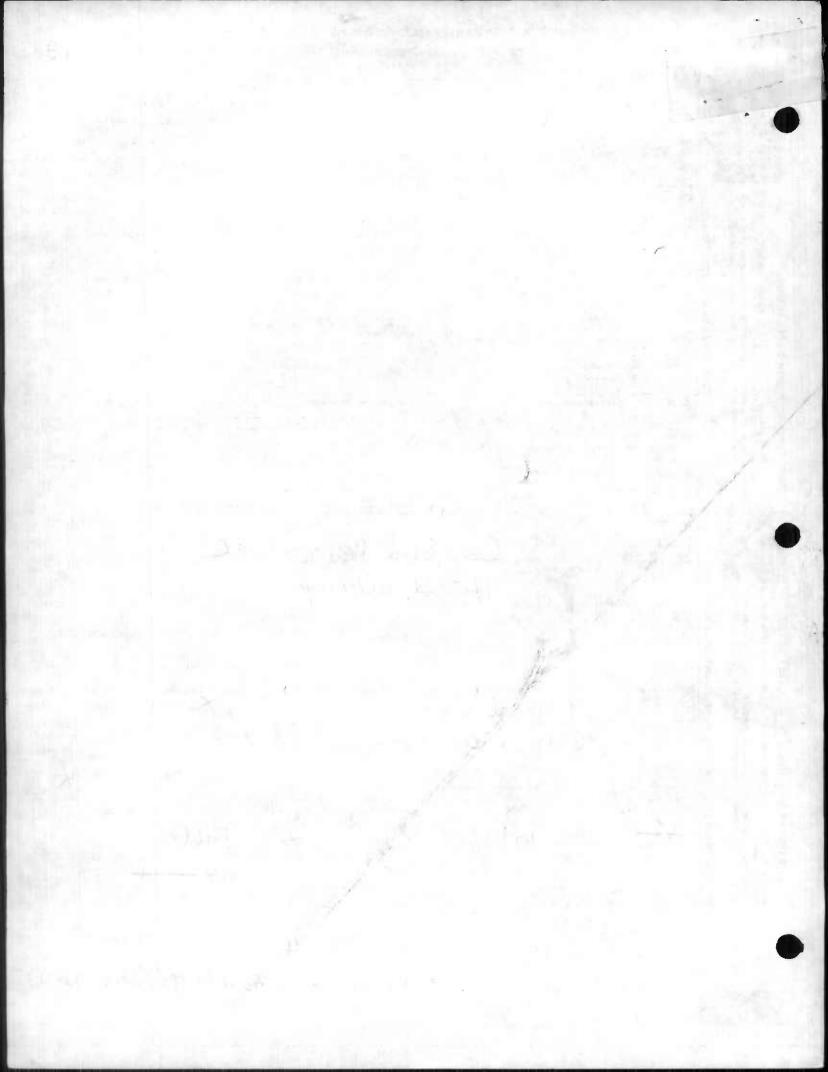
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend 1 28e, f per md G792 2/7/01 State of Maryland / Department of Health and Mental Hygiene 00 Certificate of Death Amend #27,10/11/2000, BMW, Montg. Co. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician OCT. 4, 2000 THOMAS 7:29PM DAVIS #Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY P.G. Hours Min. 8. Date of Birth (Month, Day, Year) SEPT 17 1 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** 10XM 20 F Months Days 248 68 5838 Yrs. 1942 Director 58 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits rai', or items 23s or 28s-f show YYes 2 No MD. P.G. Director CAPITOL HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 605 ELFIN AVENUE 20743 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ◯ No Specify: Specify: BLACK þ 3X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) se filed within 7 lal Hygiene. PVT. Elementary/Secondary (0-12) College (1-4or 5+) SUPV. MOVING CO. 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if item 27 is marked othe eny injury or other traumatic avent, page. 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) ODELL DAVIS MAGNOLIA LONG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) THOMAS E. DAVIS JR./SON 605 ELFIN AVENUE, CAPITOL HEIGHTS, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XDBurial 2 Cremation 3 Removal from State 10/8/00 NEWBERRY, S.C. 4 □ Donation 5 □ Other (Specify) CHURCH CEMETERY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility WATSON F. H. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. 20010 Approximata interval Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting In death) /Medical Examiner Examiner attending physician and i for use es the burial-transit Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of Physician/Medical Due to (or as a consequence of): P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? the 1 No 2 No 3 Probably 4 Unknown signed by Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed eged 1 Yes 2500 1 Yes WNO of Vital 25. Wes cese referred to medicel examiner? Be 26. Place of Death (Check only one) 1 Yes 28 No Hospital: Nunpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To this 28e. Date of Injury 27. Menper of Deet 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Division or Attending 5 Pending investigation REMOREM all after deeth.

Director: Aft
d in by the fur 11/00 1 Yes 2 710 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) street 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm street factory, office building, etc. (Specify) 4 \(\text{Homicide} \) To the Hospital o within 24 hours aff To the Funerel DI completely filled in street 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of continer 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOAD # 6CHEVERY MOOS 600 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2000 10 Registrar

DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	per md G792 2/7/01 yf	4	Certificate o			. No.	43623	
Physician	Decedent's Name (First, Middle, Las			2. Dete of Deeth Month	Day Yea			
/Medical	HENRY C. GIBI		4b. City, Town, or Local	EC. 28	4c. County of De	1305		
Examiner	4a Fecility Name (If not institution, give			ANNAPOLIS	anon or o cour		RUNDEL	
Funeral	ANNE ARUNDEL ME 5. Social Security Number 6. Se		rthday) If Under 1 Yes		3. Dete of Birth (Month, Day, Y		Birthplace (State or Foreign Country)	
Director	216-16-4085 Usual Residence of Decedent	^{2M 2□ F} 76	Yrs. Months Day	s Hours Min.	OEC. 30	1923	Country)	
laryland show ed at	10e. State 10b. County	10c. City, Tow	n or Location				10d. inside City Limits	
with the Maryland a or 28a-f show Le routhed at	MARYLAND ANNE AF	RUNDEL ANNA	POLIS				1∭ Yes 2□No	
or 28s-f s be reathed	10e. Street and Number		10f. Zip Code		10g	. Citizen of What	Country?	
th w	45 COLLEGE CREE	EK TERRACE	21	401		USA		
urs efter death vall; or hems 23d	11. Merital Status 1 Never Merried 2 Merried 3 Widowed 4 XDivorced	12. Wes Decedent Ever in U,S. Armed Forces? 1 (X)Yes 2 □ No If Yes, Give Year or Detes: 1944-4	If Yes, specify Cu	Hispanic Origin? (Speciben, Mexican, Puerto Roon of Specify:	ify Yes or No- ican, etc.)	14. Race - Ar Black, Wi Specify:]		
thurs the			Decedent's Usual Occ	upetion	16	b. Kind of Busines	ss/Industry	
ed within 72 hours effer ygiene. Yer then "natural", or titu it, the Medical Exercitor Completed by Fu	(Specify only highest grad Elementary/Secondery (0-12) 1 2 t h	college (1-4or 5+)	'life. DO NOT use reti	e during most of working red)				
年工を 2 の	17. Father's Name (First, Middle, Last)	U I	MESSENGER	18. Mother's Name			ACADEMY	
- e g = a	HENRY C. GI	BBS SR.		FLOSS	IE MATT	PWZH		
SPEE	19e. informent's Name/Reletionship (7		o. Meiling Address (Stre	et end Number or Rural	Route Number, (City or Town, State	a, Zip Code) 21403	
127 T	DEBRA GIBBS (DA		OO B HILL				DLIS, MD.	
of Head	20a. Method of Disposition	comete	of Disposition (Name of			c. Location - City		
	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removel from Stete	AND VETER		4/01 CH	ROWNSVII	LLE, MD.	
permit. Pag Department Important: It any Injury o	21. Signature of Funeral Service Licans		22. Name end Add	ress of Facility				
Depa Impo	12 M X	2 4 00 600		E & SONS				
	23a. Pert1. Enter the disease, or comp	elece MO983 illoetions thet caused the deeth. Do		ST. ANNA ying, such es cardiac or			Approximate	
Physician	shock, or heart failure. List only of	ne cause on each line.					Interval Between Onset and Death	
/Medical	immediate Cause (Final	Promoto	- E.	eme				
Examiner	disease or condition resulting in death)	a. Copusto (or as a	consequence of):				1	
اق ا	and the state of	- Asqual	ACID	IRATION PNEUM	ONIA			
n and rattransk Examiner	Sequentially list conditions.	-7-11						
	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury							
physician the bu	that initieted events	c. Due to (or as a consequence of):						
Vec P	resulting in death) Last Conancous Antenna Desiase							
and and		d					1	
of by the attending laterable for use in Physician/M	Part II. Other significant condifions co	ntributing to death but not resulting i	in the underlying cause	given in Part I.	23b. Dld tob	ecco uae contrib	uta to the cause of deat	
Phy Phy	Throat Car	Αν.α			1 🗆 Yee	2□ No 30	Probably 4 Unknow	
	1 rocare Cru	CCI				/		
cate has been signed page 2 should be c	Pinto C	3460-			24a. Was an performe		 Were eutopsy findings evailable prior to completion of cause 	
as b	- Contract C						of death?	
Hall Hall					1 ☐ Yes	22 No	1 ☐ Yes 2 ☐ No	
entifica ector, Be C	25. Wes case referred to medical exeminer?			26. Place of Death	(Check only one)			
Thysic mis ca si dire	1 Yes 2 No	Hospitel: 2 ER/O	utpatient 3 DOA	Other: 4 Nursing Hom	e 5 🗆 Residen	ce 6 Other (S	ipecify)	
	27. Manner of Death Naturat 5 Pending Accident investigation	3d. Describe how	injury occurred					
tal or Attending P rs after death. Is Director: After I led in by the funer Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, for building, etc. (Specify)	erm, street, factory, office	е 2	Bf. Location (Stre City or Town,		Rural Route Number,	
	29a. Certifier Certifying Phy	eiclan: To the best of my knowledge	e, death occurred at the	time, date and place, a	nd due to the cau	se(s) end menner	as stated.	
Hospital 24 hours Funeral stely filled dical C	(Check only 2 Medical Exam	Iner: On the basis of examination ar	nd/or investigation, in m	y opinion, death occurre	d at the time, dat	e end place, and o	due to the cause(s)	
		Iner: On the basis of examination are and manner stated.		y opinion, death occurre		e end place, and o		

State Registrar

JAN 0 5 2001

30. Name and address of person who completed cause of death (fem 23a) (Type, Print)

Charles W. Phelps and Anne Avandal Meel, al Center Annapolis MD 21

31. Date filed (Month, Day, Year)

JAN 0 5 2001

AN 0 5 2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 3 6 2 4

Physicia	1. Decedent'a Name (First, Middle, Last)	2. Date of Deal	th Day O Year	3. Time of Deeth							
/Medica	al		er 4, 2000	11:00 P.M.							
Examine	4a Facility Neme (If not institution, give street and number) 4b. City, Town 1370 Primrose Road Annag	n, or Location of Deeth	Anne Arun								
Funeral Director	577-20-4517 1EM 2LIF 88 Yrs.	Hrs. 8. Dete of Birth (Month, Day, Mar. 19	, 1912 Mai	hplece (State or Foreign unity) ryland							
famd M	Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits							
o Mar last at	Maryland Anne Arundel Annapolis			1 ☐ Yes 2 No							
	Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 1370 Primrose Road 21403	1	0g. Citizen of What Co USA	untry?							
020	13/0 Primrose Road 21403 11. Merital Status 1□ Never Merried 2□ Married 3 ☑ Widowed 4□ Divorced 1 □ Yes, Give Year or Dates: 21403 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Filtyes, Give Year or Dates: 1 □ Yes 2 ☑ No Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, White Specify: B13	e, etc.							
15-0 72 hc	15. Decedent's Education (Specify only highest grade compileted) (She kind of work done during most of life. DO NOT use retired)	of working	16b. Kind of Businass/ State High								
1121 within ene. then	15. Decedent's Education (Specity only highest grade completed) [Seeing only highest grade completed] [Give kind of work done during most of life. Do NOT use retired) [Laborer 17. Father's Name (First, Middle, Last) [Seeing only highest grade completed] [College (1-4or 5+) [Administrat	*							
d Hyging other	17. Father's Name (First, Middle, Last)	s Nama (First, Middle, I									
/lar	Leroy Simmons Emma		Waters								
e, Maryland 1 and 2 should be file Health and Mental Hy en 27 is marked othe ther traumatic event.	19a. Informant's Name/Relationship (Type, Print) E11a Green/Daughter 19b. Mailing Address (Street and Number 1370 Primrose Road		, City or Town, State, 2 , MD 21403	Zip Code)							
altimore, mil. Pages 1 as pariment of Hea postanti il ilem il y injury or other ca.	20a. Method of Disposition 1 \overline{\Omega} Burial 2 \subseteq Cremation 3 \subseteq Removal from State 4 \subseteq Donation 5 \subseteq Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Moses Cemetery		1/9/00 Lothian, MD								
Balt permit Depart Import may inj ance.	21. Signature of Funaral Sarvice Licensee 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick,										
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line.	ardiac or respiratory arr	ast,	Approximata Interval Batween Onset and Death							
Physician /Medical Examiner	Immediate Cause (Final disease or condition rasulting in death) e. Renal Fail well		2 years								
E. 7	Due to (or as a consequence of): DIABETES MELLITIS Sequentially list conditions, ff any, leading to immediate cause. Enter Underlying.										
68760, ficate be executed physician and is the burial-transit											
687 ficate ficate sp the	that initied events resulting in death) Last Due to (or es e consequence of):										
Box death certification of for use a	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did to	23b. Did tobacco use contribute to the cause								
ss that the de igned by the be detached	Diabetes mellito	101	res 2 KNO 3□P	robably 4 Unknown							
Division of Vital Records, P.O. Box or Attending Physician: The law requires that the death certificate has been signed by the attending in by the funeral director, page 2 should be detached for use at the control of	Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 25. Was case referred to medical examiner?	24a. Was a perfor	med?	Wara autopsy findings available prior to completion of causa of death?							
The law		1 D Y	es 2X No	1 ☐ Yes 2 ☐ No							
Vital Property Securificate director, pag		26. Placa of Daath (Check only one)									
Vision of Vita			enca 6 Other (Spe ow injury occurred	city)							
lon ath. :: After se funer	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury at Work? 2 Accident investigation 28c. Injury at Work? 1 Yes 2 No	The second									
Division or Attendate the Director:	3 Suicide 6 Could not be determined 4 Homicida determined 28e. Place of Injury - At home, ferm, street, factory, offica building, atc. (Specify)	28f. Location (S City or Tow	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Division To the Hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the	27. Manner of Death Natural										
To the comp	29b. Signature and title of confirm 29c. License number	8563	29d. Date signed (Mont	th, Day, Year)							
10	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vayne Bic bayn My 134 OWENSVIlle Rd	1. West	River n	M							
State	24 Date filed (Month Day York) 20 Desistants Complying	1	1 -1 -								
Registra	MOV UU ZUUU Dener De aparles										

Buch S.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend item 23a,b per md G792 2/9/01 yf State of Maryland / Department of Health and Mental Hygiene
AMEND ITEM #5 AS PER FUNERAL HOME 11/01/2000 CCHD FCB Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Washington Ruby 23,2000 October 16:31 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Southern Maryland Hospital

5. Social Security, Number 6. Sex 7. Age (In yrs. last birthday) Clinton Prince Georges If Under 1 Ye 8. Date of Birth (Month, Day, Year)
April 14,1915 Maryland 5. Social Security Number 578-28-8823 Funeral Hours Deys Months 1□ M 2□X 85 Director 217 36 9580 Usuat Residence of Decedent the Menyland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or flems 23s or 28s-f show traumstic event, the Machail Exertines must be motified at 1 Yes 2 No Director Maryland Prince Georges Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 10701 Cedarville Road U.S.A. 14. Race - American Indian, Funeral 20613 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry se filed within 7 ial Hygiene. Elementary/Secondery (0-12) Cotlege (1-4or 5+) 12 Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be f h end Mental Howard Robinson Priscilla Hawkins Teldson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2: Department of Health el Important: If Item 27 is Janet Barber/ Daughter 2266 Hope Circle, Waldorf Maryland 20601 other 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ò 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem.Oct. 27, 2000 Clinton Maryland inlury 21. Signature of Funeral Service Licanses 22. Name and Address of Facility H 191 Adams Funeral Home P.A. Aquasco MD 20608 23a. Part1. Enter rie disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Ceuse (Final diseese or condition resulting in death) rivieurea 29/ hu a. Payed nonA Examiner Due to (or es a consequence of): Examine Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es a consequence of): pue the attending physician death certificate be Physician/Medical that initiated events resulting in death) Last the Due to (or as a consequence of): 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? be detached been signed by 1 Yes 2 No 3 Probably 4 Unknown þ Wer Washington 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? CADNON has 1 Yes 2 No After this certificate Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ tnpatient 2 ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) Director: After this 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred Attending 5 Pending investigation 1 Yes 2 No death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide b To the Hospital

within 24 hours a

To the Funeral C 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Fire 0001929 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fredoson MA Len Opro

DHMH 16 Rev 6/95

Registrar

31. Date filed (Month, Day, Year)

OCT 2 5 2000

ORIGINAL

32. Registrar's Signature

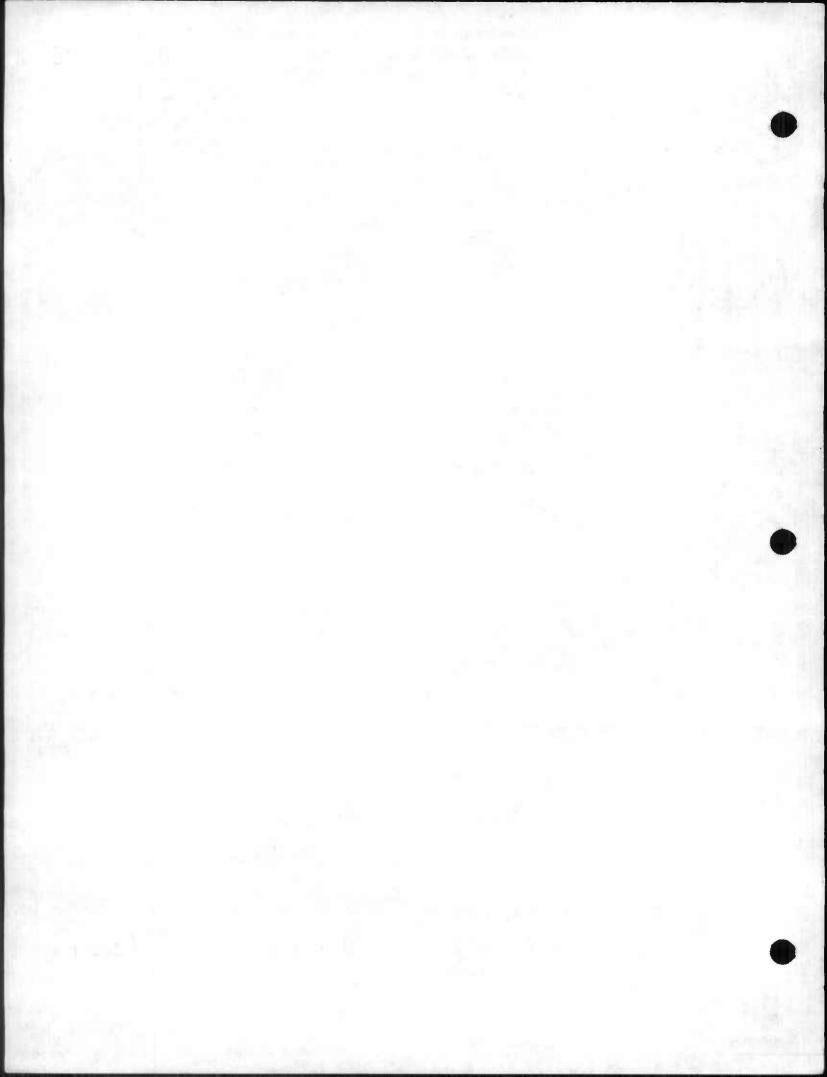
OCT 25 2000 Summer St. America

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State of Maryland / Department of Health and Mental Hygien 0 43626

				Certifica	te of	Death		R	g. No.	7 6	0000
Dhysisian	1. Decedent's Neme (First, Middle, Las	(1)	1					ete of Deet		Year	3. Time of Deeth
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Examiner	4a Facility Neme (If not institution, give					4b. City, Tow	vn, or Location	of Deeth	4c. County of	of Death	
	Baltimore VA	nedical co	enter				imore			.mor	e City
Funeral	Social Security Number 6. S	ex 7. Age (//	n yrs. lest birt	Month	er 1 Yeer s Days	If Under 2 Hours	Min. 8. Da	te of Birth lonth, Dey,	Year)	9. Birthp	place (State or Foreign htry)
Director	199 30 3214	5/11 6	1	rs.			5-	14 - 1	939	Pen	nsylvania
pu s	Usual Residence of Decedent 10a. Stete 10b. County	10	c. City, Town	or Location						1	0d. Inside City Limits
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the M	MD Anne Ru 10e. Street and Number	inder	Gren		ip Code			1 4	Og. Citizen of W	Post Cour	A star 2
23a or											
ifer death with the Maryland r terms 23s or 28s-1 show ther must be notified at funeral Director	1803 Lansing F	(CL 12. Was Decedent Eve	r in II C		2106		in? (Specify V		nited		ces an Indian,
		Armed Forces?	1 11 0,0.	If Yes, sp	ecify Cub	an, Mexican,	in? (Specify Y Puerto Rican	etc.)	Black	k, White,	etc.
" O >	1 ☐ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Detes:		1 ☐ Yes	3X7X10	Specify:			Specify:	Whi	te
"natural",	15. Decedent's Ed		16e.	Decedent's Us	uel Occur	nation			16b. Kind of Bu	siness/Inc	dustry
	(Specify only highest gra	de completed)		(Give kind of w life. DO NOT	vork done use retire	during most	of working				
i within in the Me	Elementery/Secondery (0-12)	College (1-4or 5+)	Mai	ntena	nce				Hotel		
tal Hygin d other avant, II	17. Fether's Name (First, Middle, Last)					18. Mother	's Neme (Firs	t, Middle, I	Aaiden Sumemi	B)	
Menta Menta arked affc av	James W. Lane					Elve	ena Do	wnir	α		
2 should be filed and Mental Hygi Is marked other reumatic avent, To Be Co	19a. Informent's Name/Reletionship (7	Type, Print)	19b.	Mailing Addre	ss (Street				City or Town,	Stete, Zip	Code)
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permit. Pages 1 end Department of Health Important: If Itam 27 any injury or other to once.	21. Signeture of Funeral Service Ligen		OIIICE	22. Neme	end Addre	ess of Fecility	/			71 00	
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be executed ician end burial-transit	Sequentially list conditions, if any, leading to immediate	Du	a to (or as a c	consequence of	1).						
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or Attending after death. Director: After J in by the fune ertification	1 Netural 5 ☐ Pending	28a. Dete of Injury (Month, Dey Yo	ear) Ir	njury M	28c. Inju Wo	rk?]Yes 2□1			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Attending r death. Actor: Afte by the fune	3 Suicide 6 ☐ Could not be						31. Location (Street and Number or Rural Route Number,				
or A	determined 4 Homicide 28e. Plece of Injury - At home, farm, street, lactory, office building, etc. (Specify)							ity or Town			
Hospital 24 hours Funeral stely filled	29a. Certifier 1/X Certifying Ph	ysician: To the best of m	v knowledne	death occurre	d at the ti	ime date and	t place, and d	ue to the c	ause(s) and me	nner es s	tated
To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 7	(Check only 2 Medical Examone)	iner: On the basis of ex	aminetion end	Vor investigation	on, in my	opinion, deet	h occurred et	the time, d	ete end place, a	and due to	o the ceuse(s)
within 2 To the comple	29b. Signature and title of certifier			2	9c. Licen	se number		2	9d. Date signed	Month,	Day, Year)
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	30. Name end address of person who c		0 N 0 F		KEE	N)c	ST.	AA	UT. A	AD	
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DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 00 43627

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Certificate of Death 2. Date of Death 1. Decedent'a Name (First, Middla, Last) 3. Time of Death Physician JULY 30, CHRISTOPHER 2000 08:48a.m RICE /Medical 4b. City, Town, or Location of Deeth 4a Facility Nama (ff not institution, giva street and number) 4c. County of Deeth Examiner Prince Frederick Calvert Calvert Memorial Hospital If Undar 1 Yeer | If Under 24 Hrs. 6. Sex 8. Data of Birth (Month, Dev. 5/11/60 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) Months Days Hours Yrs. 163-54-9894 40 Director Lancaster, Pa. Usual Rasidenca of Decedent with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits or Nerna 23a or 28a-f show the Medical Examiner must be notified at Yas 2 No Solomons Island Directo Md. 10f. Zip Coda 10g. Citizen of What Country? 10e. Street end Number 20688 U.S.A. 14648 S.Solomons Island Apt.3 Funeral 12. Was Decedant Evar in U,S. Armed Forces? Was Decedant of Hispenic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. Biack, Whita, elc. filed within 72 hours after 1√ Yas 2 No If Yas, Giva Year or Dates: 78–82 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Spacify: Specify: þ 3 Widowed 4 Divorced White "natural". Completed 15. Decedent's Education (Specify only highast grada complated) 16e. Decedent's Usuat Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry al Hygiene. Elementary/Secondary (0-12) Cottege (1-4or 5+) Cable Electric Technician 12 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fethar's Nama (First, Middla, Last) Pages 1 and 2 should be nant of Health and Mental Int: If Item 27 is marked o Doris E. Kelley Elwood K. Rice 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code) opartment of Health as important: If Item 27 Ia n eny Injury or other RDCs. Doris E. Rice 222 W. Donegal St. Mount Joy, Pa. 17552 20b. Placa of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, State 20e. Mathod of Disposition Burial 2 Cramation 3 Removal from Stala
4 Donation 5 Other (Specify) Henry Eberle Cemetery 8/3/00 Mount Joy, Pa. 21. Signature of Funaral Sarvice Ligensea 22. Nama and Addrass of Facility 600 Main St. Harkins Funeral Home, Inc., Delta, PA anti. Enter the disease, or complications that caused tha daath. Do not anter the moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona cause on each lina. Approximata Intarval Between Onset end Death **Physician** /Medical Immediate Cause (Final disaase or condition rasulting in daeth) He patic Failure
Due to (or as a consequence of) Examiner Examiner Renal Failure Sequentially list conditions, if eny, laeding to immediata cause. Entar Undarfying Cause (Disease or Injury that initiated events rasulting in death) Lest Dua lo (or es e consequanca of): and ALCOHOLISM Physician/Medicai Due to (or as e consequence of) cate has been signed by the a page 2 should be detached it 23b. Did tobacco use contribute to the cause of death? Part It. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ of Vital Records. 24b. Were eutopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performad? this certificate has 1 Yas 285No 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Was casa referred to medical 26. Placa of Death (Check only ona) Hospital: 2 ER/Oulpatient 3 DOA Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 10 1 Yas 2 No 27. Manner of Death 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 28b. Tima of After Division 5 Panding Injury sefter death. 1 Yes 2 No 2 Accidant investigation 6 Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) filled in by 4 Homicida To the Hospital c within 24 hours at To the Funeral D Medical Examiner: On the best of my knowledga, daath occurred at tha tima, dete end piece, and dua to the causa(s) end mennar as stated.

Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, dete and piece, end dua to the ceuse(s) and mannar stated. 29a. Certifier Medical completaly 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatura and title of certifier Lardy MD July 30, 2000 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) DAVID TARDIO PRINCE FREDERICK, MD 20678 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

DHMH 16 Rev 6/95

State

Registrar

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2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien amend item 27 per me G792 2/6/01 yf Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death Month **Physician** Desore 1130 Kobinson 2000 Sep /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** County Hospital Hagerstown Washing ton Washington 5. Social Security Number If Under 1 Year | if Under 24 Hrs. 6 Sex 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) **Funeral** Months Deys Hours Min 1 M 28 F 96 161-24-9593 Yrs. Director 20, 1904 Waynesboro, Pa Jan Usuel Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show "natural", or items 23s or 28s-f shades Examiner must be notified KerKeley 18 Yes 2 No talling Waters Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 25419 316 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No if Yes, Give Yeer or Dates: 13. Was Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American indien, Black, White, etc. 11. Maritei Status 1 Never Married 2 Merried Maryland 21215-0020 1 ☐ Yes 2 BNo Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed traumatic event, the Medical 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementery/Secondary (0-12) College (1-4 or 5+) 12 Clothing esigner 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Pages 1 and 2 should be nent of Heelth and Mental Norles M. Stoner Grace E 19e. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Lepartment of Heelth ar Important: If item 27 is n 60 Stoner Nellie A Sister Alling Waters WV 25 419 316 Just \$ Baltimore, 20e. Method of Disposition 20b. Pieca of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) umberland Valley (rem. Waynesbon 22. Name and Address of Facility rove-Borners or Farners Home 21. Signeture of Funeral Service Licensee 10 23e. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart fellure. List only one cause on each line. 17268 Approximete intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Fine) MYOCARDIAC INFARCTION 5 MIN. diseese or condition resulting in deeth) **Examiner** Due to (or es e consequença of): Examiner D. ARTERIOSCLEROTIC CORDMANY APTERY 15YRS DISCASE Sequentielly ilst conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest buriel-tran Due to (or es e consequenca of): physician s the buriel Physician/Medical Due to (or es e consequence of) 98 nding Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 ☐ Yes 2 PNo 3 Probably 4 Unknown HIP FRACTURE AUGUST 8 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? page 2 should Completed 24e. Wes en eutopsy performed? certificete 2 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) 1 No 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA this 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred After t 5 Pending investigation fall down stairs 1 Edvatural Injury death. 1 Yes 2 No 1100 0 or Attend e efter death Director; 2 Accident Aug 24 2000 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 4 Homicide To the Hospital o within 24 hours of To the Funeral Di completely filled in at home Helpesylle WV 25427 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pieca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end pieca, end due to the ceuse(s) end menner steted. Medicai (Check only

State Registrar

29b. Signeture end little of gentifier

30. Name end address of person who completed cause of deeth (item 23e) (Type, Print)

Howard N. Weeks, M.D. 580 NOrthern Avenue, Hagerstown, MD 21742 31. Dete filed (Month, Dey, Year) SEP 1 2 2000 32. Registrer's Signeture

29c. License number

D001266

29d. Dete signed (Month, Day, Year)

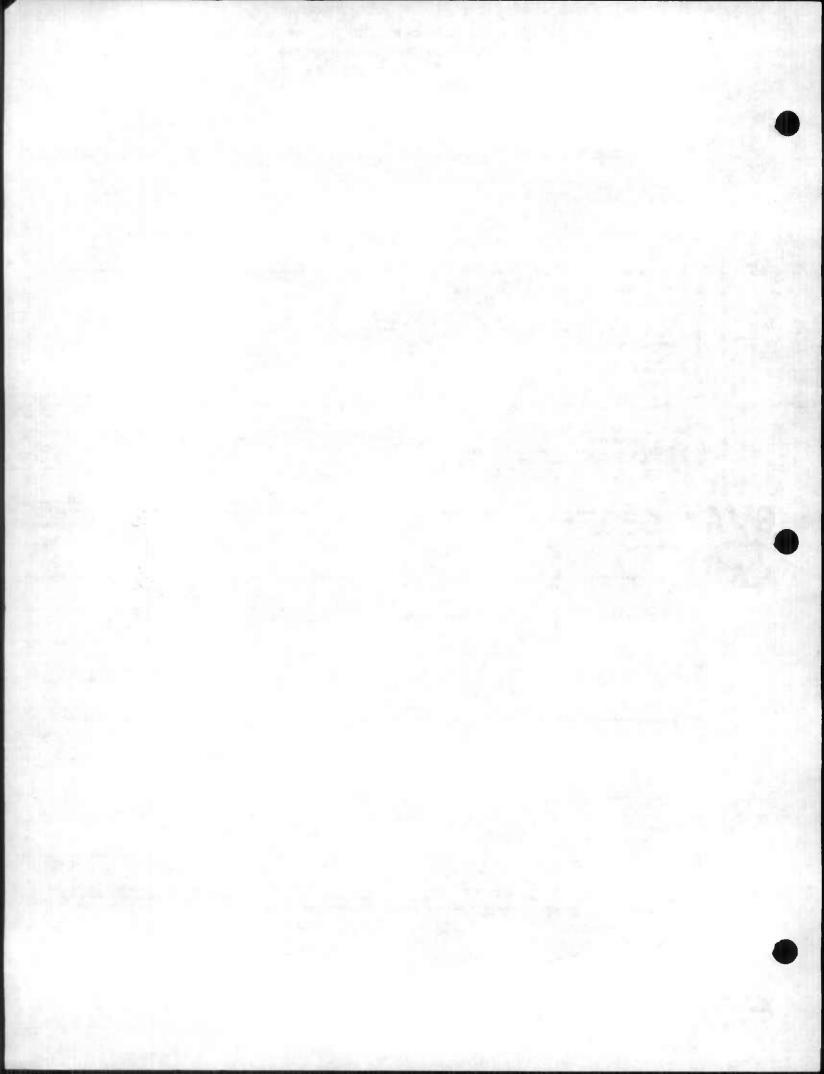
September 12,2000

months of a comment while the soft to be tell thought to be an out- 2 with the soft of the soft of 30 m

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierle U amend item 23a,27,28haffaper me G792 2/14/01 yf Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October **Physician** 2000 Antoinett Marie Bernazzani 8:30 A M /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth **Examiner** 46351 Columbus Drive, Apartment 201 Lexington Park St. Mary's 7. Age (In yrs. lest birthdey) If Under 1 Year It Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) July 20, 1953 3 5. Societ Security Number UNKNOWN Birthplece (State or Foreign Country) **Funeral** 1 M 2 TF California - LECOULAD **Director** Usuet Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County St. Mary's Maryland Lexington Park 1 ☐ Yes 2 No Directo 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 46351 Columbus Drive 20653 United States 238 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0·12) College (1-4or 5+) unknown unknown 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Ralph Anthony Bernazzani Delores Bailey 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MCIW, P.O. BOX 535, Jessup, Maryland 20794 Amanda Bernazanni Daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from Stete Brinsfield-Echols Crematory 10/20/2000 Charlotte Hall, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeret Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, Maryland 20650 Edward N. Brinsfield, Jr per DVR Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or reapiratory arrest, shock, or heer failure. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in death) **Physician** COCAINE INTOXICATION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): Examiner burial-tran Due to (or es e consequence of): s the burial P.O. Box 68760 Physician/Medical 98 ettending for use as IF FEMALE 23c. Il yea, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnent at time of death 23d. Dete of delivery 23b. Wes decedent pregnent 3 Ectopic pregnancy Day Month Year in the pest 12 months? 5 Other (specify) signed by the e 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Munknown Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobecco use contribute to the cause of deeth? Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probebly 4 ☑ Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☑Yes 2 ☐ No 24a. Was en certificate has lifector, page 2: 1⊠Yes 2□No Division of Vital . Hospitat or Attanding Physician: 24 hours efter death. Funaral Director: After this certifice tiely filled in by the funeral director, p. 25. Wes case referred to medical examiner? 28. Place of Deeth (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Nother (Specify) at scene 2 1 XYes 2 No for Menth, Day Year) 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred A 1 Natural 5 Pending found: unknown 1 ☐ Yes 2 XXIO investigetion 10/15/00 2 Accident 8:20 6 XX ould not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)(46351 Columbus Drive Lexington Park, Maryland 28e. Place of Injury - At home, Ierm, street, fectory, offica building, etc. (Specify) found: residence 4 Homicide within 24 hours a To the Funeral C completely filled The continuous Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Metrical Similar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29d. Dete signed (Month, Day, Yeer) 29c. License number 29b. Signature and to Forla 2-15-01 OUME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Mary G. Ripple, M.D. 31. Date liled (Month, Dey, Year) 15 2001 32. Registrar's Signature State rener Registrar DHMH 17 Rev 1/2001



CLYDE DUNCAN

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Physici /Medic Examin

Funeral

Director

hen 27 is marked other than "netural", or hems 23s or 28s-1 show other traumetic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Physiens. Important: If Isen 27 is net/sed other ban "netural", or the any injury or other traumatic awant the Mandral Feature Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the funeral director, page 2 should be detached for use as the bunal-transit Division of Vital Records, P.O. Box 68760,

1. Decedent's Neme (First, Middle, Last))			30 17				2. Dete of De Month	Day	Year	3. Tima of Death
CLYDE DUNCAN									ER 23,20	000	6:55P.M.
4e Facility Name (If not institution, give s ST.AGNES HOSPITAL	street end nu	m <i>ber)</i>				4b. City, To		cation of Death	4c. County	y of Death	
5. Social Security Number Unk 6. Sex	x	7. Age (In yrs.	lest birthdey)	If Under	1 Yeer	If Under	24 Hrs.	8. Dete of Bir	th	9. Birth	placa (State or Foreign
118	M 2□F	65	Yrs.	Months	Deys	Hours	Min.	(Month, Da	y, Year) 1, 1935	Cou	ntry) Unk
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10a. State 10b. County		100.01	Baltin								1 ¥ Yes 2 No
10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Cou	ntry?
2560 Marbourne Av						21230				USA	
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unk ur	nk			100							
17. Father's Neme (First, Middle, Last)	u	nk				18. Mothe	er's Nam	e (First, Middle,	, Meiden Sumar	me)	unk
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State Registrar

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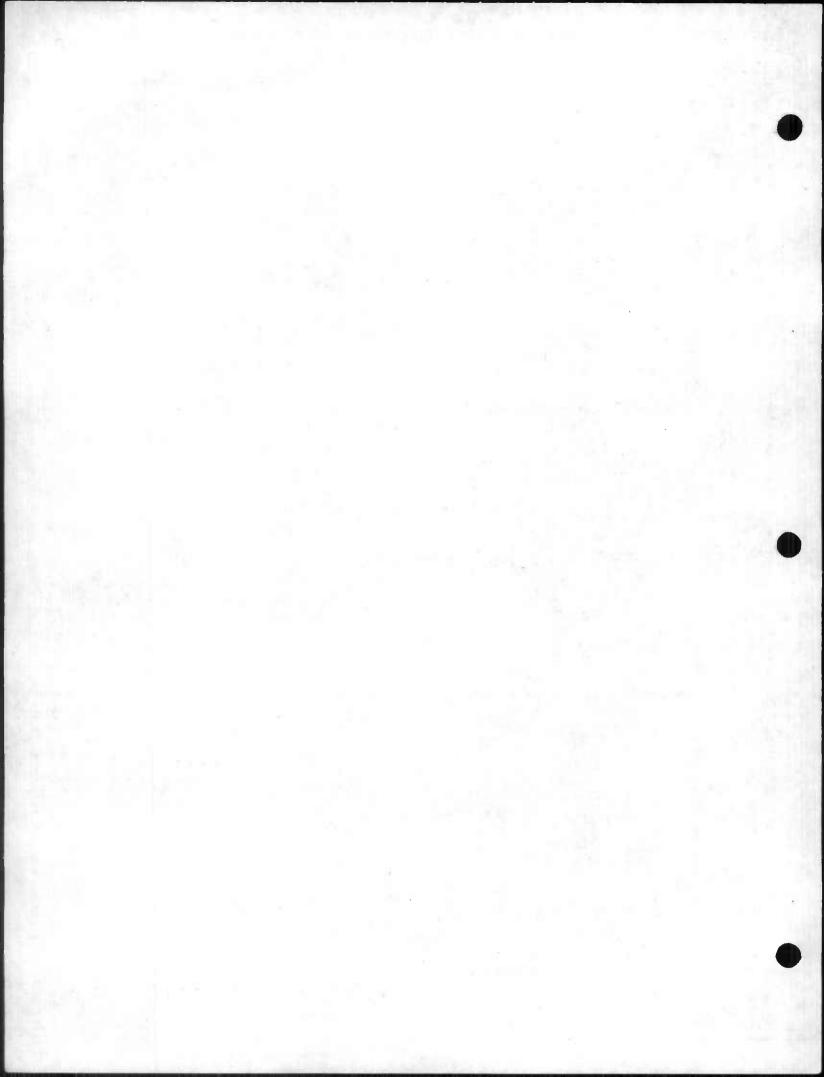
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Penn Street, Baltimore, Maryland 21201



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#27 PER PHY G794 4-21-01 WR
State of Maryland / Department of Health and Mental Hygiene 00 ADMEND ITEM: Amended#16b,01-09-01,WCHD,D0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year December 27,2000 **Physician GLADYS GODFREY** 0255 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) april 1,1920 Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 M 2 X F 80 Yrs. 218-01-1184 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland Wicomico Willards XX Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Canal Street 238 21874 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify. Specify: White 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Garment Elementary/Secondary (0-12) College (1-4or 5+) Garmet Manufacturing Seamstress Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Pages 1 and 2 should be nant of Health and Mental Leamon White Artha Davis 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of of Health : If Item 27 i Lloyd Godfrey Jr./Son 5744 Argyle Dr., Parsonsburg, MD 21849 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State 1/3/01 Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Cemetery 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Finel diseasa or condition resulting in death) /Medical Examiner Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last wint Chronac Physician/Medical Dueso (pr as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? of Vital Records, P.O. 2 1 Yes 20 No 3 Probably 4 Unknown Completed by Denzine desorder (DISORDER) 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 ☐ Yes 2 ☐ No 1 Yes 2) No or Attending Physician: Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Naturat 5 Pending investigation s after death. 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be determined 28e. Pleca of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end manner as atated.

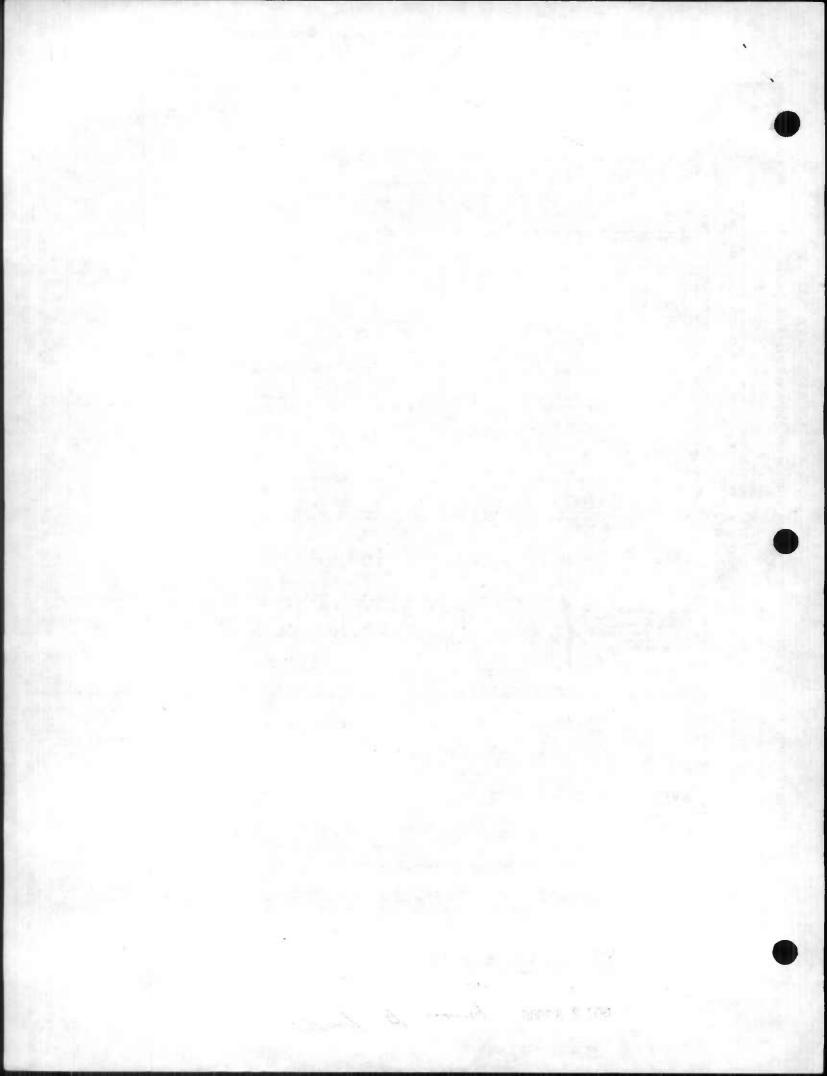
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. Medical 29a, Certifier completely within 2 To the To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 15384 12/27/00 Mich oomen 1200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RODNEY 100 POWER ST. WENRICH 31. Date filed (Month, Day, 32. Registrer's Signature State

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Registrar

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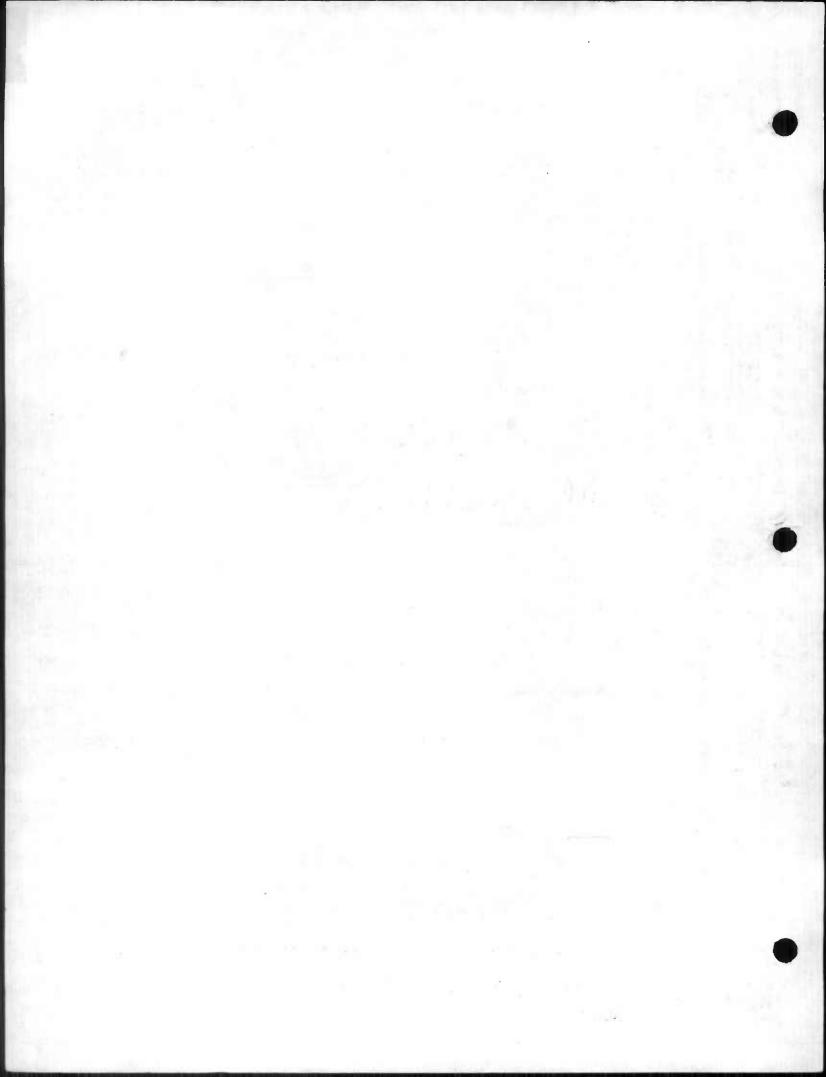


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State of Maryland / Department of Health and Mental Hygien Amend item#27 HCHD 8/22/00 bGertificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** August 1523 18 Elmer Clair Jackson 2000 /Medical 4e Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City Union Memorial Hospital If Under 24 Hrs. Hours Min. if Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** XXM 2□F Months Days Hours Yrs Director 215-16-5360 Usuel Residence of Deceden 78 Virginia 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yas 2X No Maryland Harford Director Belcamp 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1401 D Goldenrod Court 21017 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 (TYes 2 □ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indien. Black, White, etc. 1 Navar Marriad 2 Married Baitimore, Marviand 21215-0020 1 Yes 25 No Specify: Aq 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Peges 1 and 2 should be filed within nent of Heelth and Mentel Hygiene. int: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Rubber 17. Fethar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mollie Caroline Webb Jessie Tolman Jackson 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 1401 D Goldenrod Court, Belcamp, Maryland 21017 Velma F. Jackson- Wife 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Buriel 2 □ Cramation 3 □ Removal from Stete permit. Pege Department of important: If any injury or otice. 4 ☐ Donetion 5 ☐ Other (Specify) Oak Grove Baptist Cem. | 8/23/00 Bel Air, Maryland 22. Nama and Address of Facility
McComas Funeral Home, P.A. etura of Funeral Service Licensee 23a. Parm. Enter in this saese, or complications that caused the deet the not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hen't this lure. List only one ceuse on each line. 5-1317 Cokesbury Road, Abingdon, Maryland 21009 Approximete Intervel Between Onset end Death **Physician** /Medical Immediata Causa (Final myocardial inforction 3 weeks diseese or condition resulting in deeth) Examiner Due to (or es e consequence of) weeks mutiple Strokes Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest physician and s the burial-tran Due to (or es e consequence of): P.O. Box 68760, respira tory failure
Dua to (or as a consequence of): Sweeks Physician/Medical attending p 3 weeks interstitual pulmonary fibrosis Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Division of Vitai Records, by 24b. Were eutopsy findings available prior to complation of causa of death? Completed 24a. Was en autopsy performed? peen 1 Yes 2 No 1 Yes 2 No certifica or Attending Physician: Be 25. Wes case referred to medical 26. Placa of Deeth (Check only one) exeminer? Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 3 Erending 1 Neturel efter deeth. 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. 29e. Certifier pletely To the To the Comple 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signatura and title of certifier hber? m.D. AU4176435L August 18,2000 30. Name end address of person who complated cause of deeth (Item 23a) (Type, Print) 1241 Thomas Linberg M.W. 4216 Sugar Pine Ct. Burfonsville, MD 20866 31. Dete filed (Month, Day, Year) 32. Registrar's Signature AUG 2 2 2000 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien U Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Deeth 3. Tima of Death Kayet +a 10 2000 4e. Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Silver SP montgomera 6. Sex 1□M 2XF Days 201-30-2950 TULSA, Usuel Residence of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Pres 2 □ No SILVER SPRING MONTGOMELY 10g. Citizen of What Country? 20905 HAMPSHIRE AV USA 12325 12. Was Decedant Ever In U,S. Armed Forças? 1 ☐ Yas 2 No If Yes, Give Yaar or Datas: 14. Race - Amaricen Indian, Bleck, White, atc. 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Maxican, Puarto Rican, atc.) 1 ☐ Navar Married 2 ☐ Merried 3 ☐ Widowed 4 ☑ Divorced WHITE 16a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. QO NOT use ratired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Housewife 12 TOMEHAKER 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meidan Sumema) GABLE MILDRID KAYMOND 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 20984 19e. Informant's Name/Ralationship (Type, Print) MONGOMERY VILLEAGE, HD SHAUNA STEGEL LANGHTER 9867 BROOKRIDGE 20c. Location - City or Town, Steta 20a. Mathod of Disposition

1 ☐ Buriel 2 Cramation 3 ☐ Removal from Stete
4 ☐ Donetion 5 ☐ Othar (Specify) 20b. Place of Disposition (Nama of cemetary, cramatory or othar place) VATIONAL OSOCTOO FALLS CHURCH, VA 21. Signeture of Funaral Sarvice Licensee 22. Nama and Addrass of Fecility JOSEPH GAWLER'S SOUS 5130 WESC. AVE, NW, WASH, DC 20016 23a. Part1. Enter the draw wor complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or have talks us only one causa on each line. Approximata Intervei Between Onset end Death Immediate Ceuse (Final Dehydration diseasa or condition rasulting In daeth) Impaired Swallowing Sequentielly list conditions, if any, leading to Immadiata ceuse. Entar Underlying Cause (Disaase or Injury that initiated evants resulting In death) Lest Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yas 2 ☐ No 1 ☐ Yas 2 No 25. Wes casa rafarred to madical axaminar? 26. Place of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatiant 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Deeth 28d. Dascribe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Naturel 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 ☐ Could not be datermined 3 Sulcide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, ferm, street, factory, office building, etc. (Specify)

Examiner Box 68760. Records, P.O. Division of Vital

Examiner ician and burial-transit physician s the burial or Attending Physician: this funeral After after death. • Funeral Hospital

Physician

/Medical

Examiner

Director

Funeral

à

Completed

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

d 2 should be filed within 72. It and Mental Hygiena.

permit. Pages 1 and 2 Department of Health a Important: If flem 27 is any injury or other trau

Physician /Medical

Maryland 21215-0020

Baltimore,

Physician/Medical P Completed Certification:

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29a. Cartifiar

State Registrar (Check only one) 2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) end manner stated. MD

29c. License number

1 Certifying Phyaician: To tha best of my knowledga, death occurred et tha tima, data and place, and due to tha ceusa(s) and mannar es stated.

29d. Date signed (Month, Day, Year)

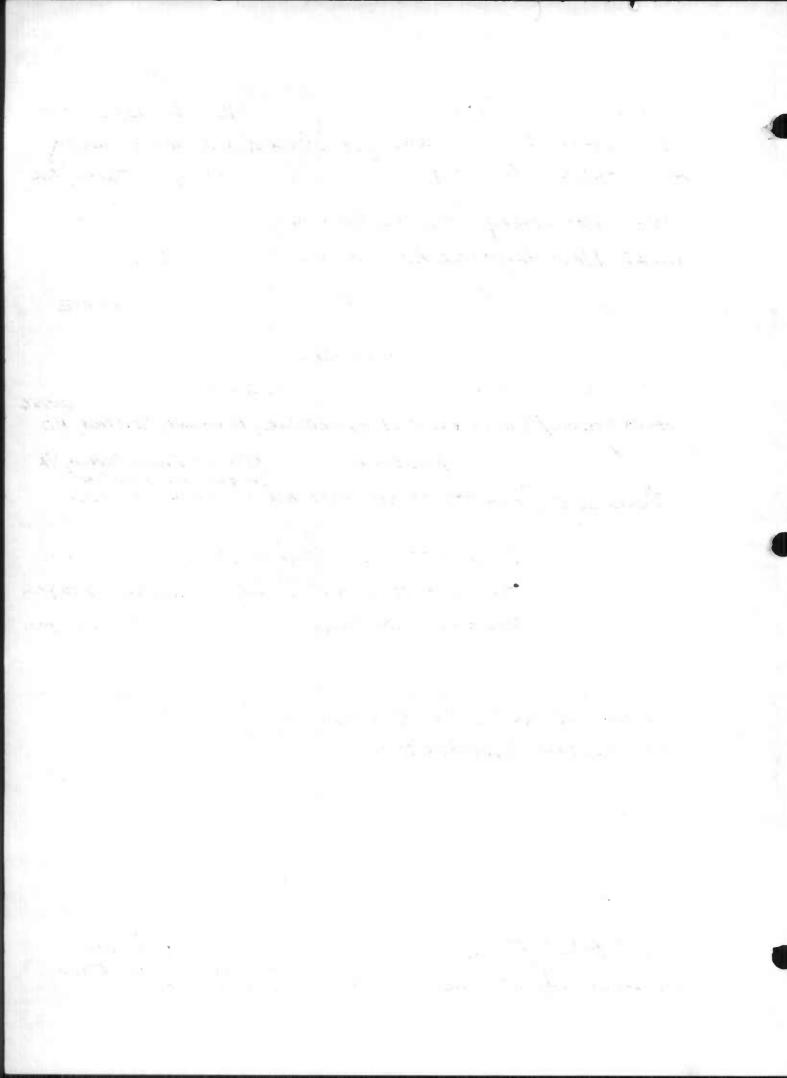
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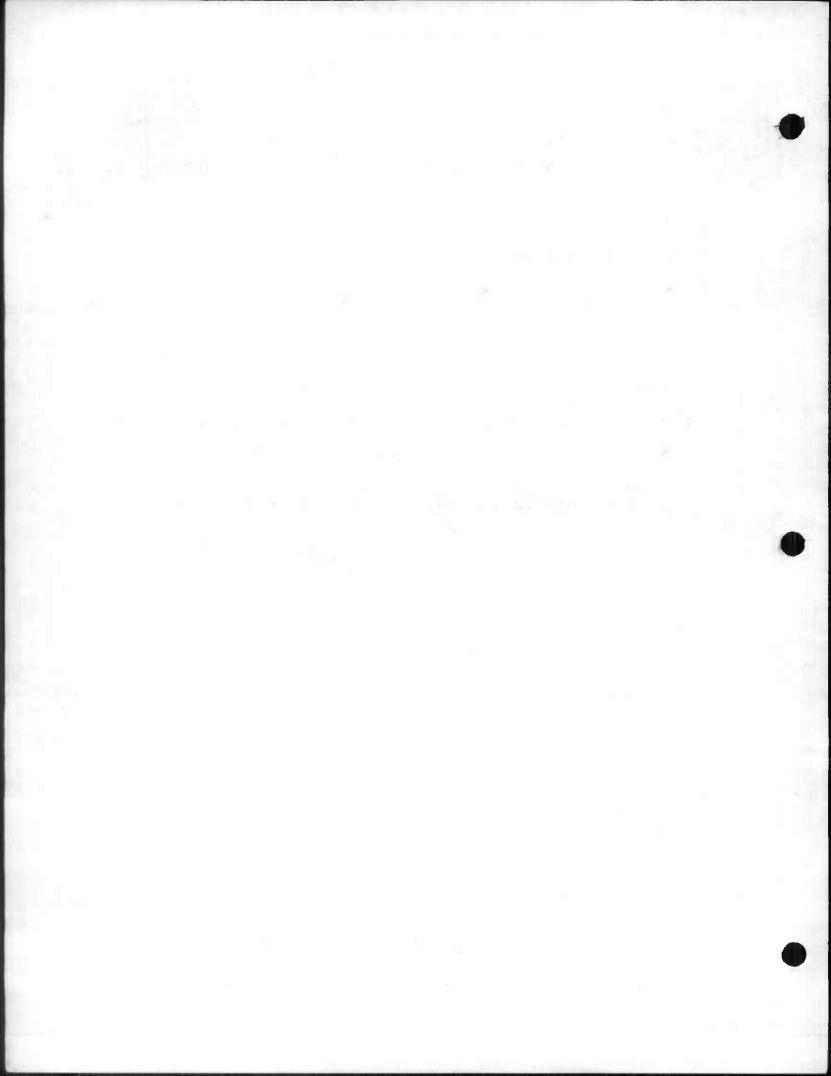
31. Data filed (Month, Pay, Year) 32. Regisfrar's Signatura

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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how		Usuel Residence of Decedent 10e. State 10b. County		10c. City, To	wn or Location						10d. Inside City
28a-f show	ctor	Maryland Wicor	nico	Sal	isbury	У					1 ☐ Yes 2
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Sel	ted	15. Decedent's Ed (Specify only highest gra	ducetion	16	a. Decedent's	Usuel Occup	ation	unding	16b. Ki	ind of Busine	ss/Industry
an "c	Completed	Elementery/Secondery (0-12)	College (1-4or	5+)	(Give kind of work done during mo life. DO NOT use retired)			OIKIII			
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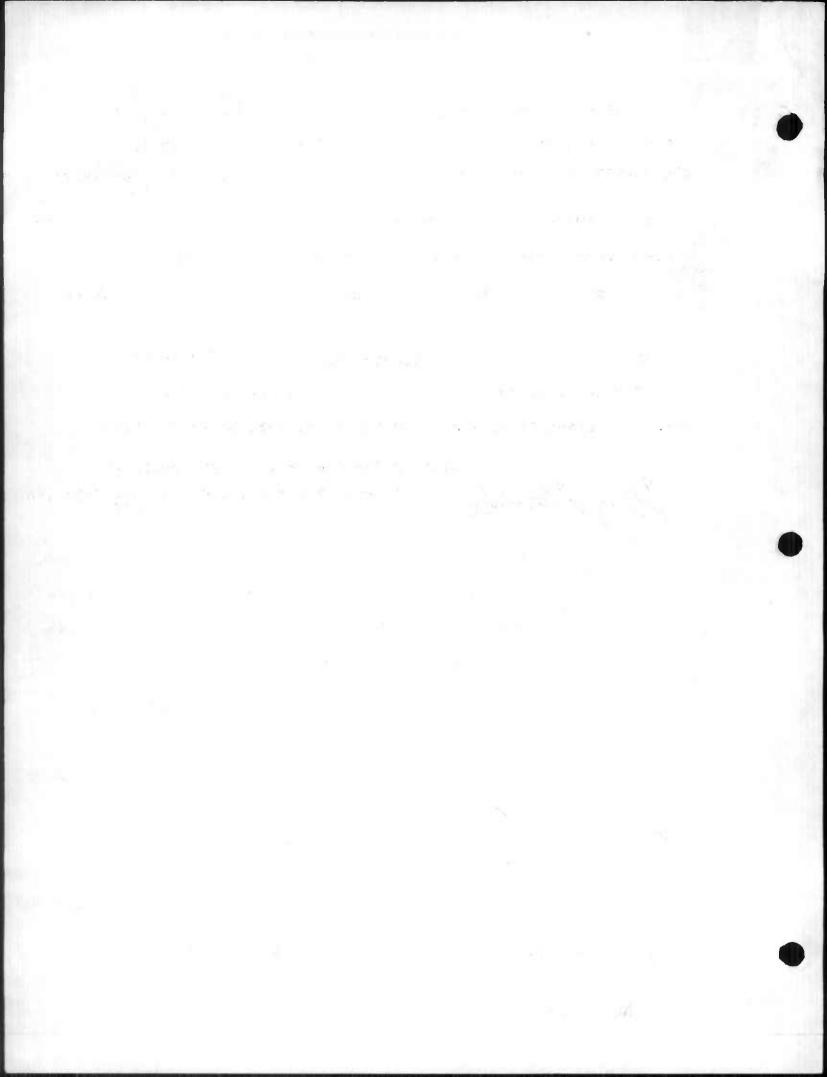
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State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3.71 mte of Death Dey Year **Physician** 1210 ISABEL M. MCLAUGHLIN 2 2000 November /Medicai 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Union Hospital E1kton Ceci1 If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Deys Hours 1 M XXF 220-20-7933 73 Yrs. 2/3/1927 Director Pennsylvania Usual Residence of Decedent the Maryland permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantel Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Machail Examples must be notified at once. 10e. Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2000 Director PA York Delta 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 368 Broad Street Extended 17314 Funeral USA 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Yes X2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Government 12 bookkeeper 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be P Catherine Snyder Delmer L. Myers 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Ralph I. McLaughlin-husband 368 Broad St. Ext., Delta, PA 17314 20e. Method of Disposition 20c. Location - City or Town, Stete Dete Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Slate Ridge Cemetery 11/6/00 Delta, PA 21. Signature of Funerel Service Licenser Harkins F.H. Inc., 600 MAin St., Delta, PA briter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. 17314 Approximete Intervel Between Onset end Deeth **Physician** /Medicai Immediate Cause (Finel MRSA SEASIS diseese or condition resulting In death) 2 unda Examiner Examiner CLERWOSIS. LIVER FALLUNG sician end burial-transit Box 68760, 年 Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequenca of) physician s the buriel HEPATITIS C Physiclan/Medical Due to (or es e consequença of): LIVER CANCER DF THE 2 9 comos P.O. F Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detec 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings evailable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed page 2 hes 1 Yes 2 2No 1 ☐ Yes 2 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours effor death.
To the Funeral Director: After this certifica completely filled in by the funeral disorder. 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 1 Neturel 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homlcide 12 Certifying Phyelclan: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) 29b. Signeture end title of cartifier 29c. License number 29d. Dete signed (Month, Day, Year) 11-2-00 00007463 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 5

State Registrar



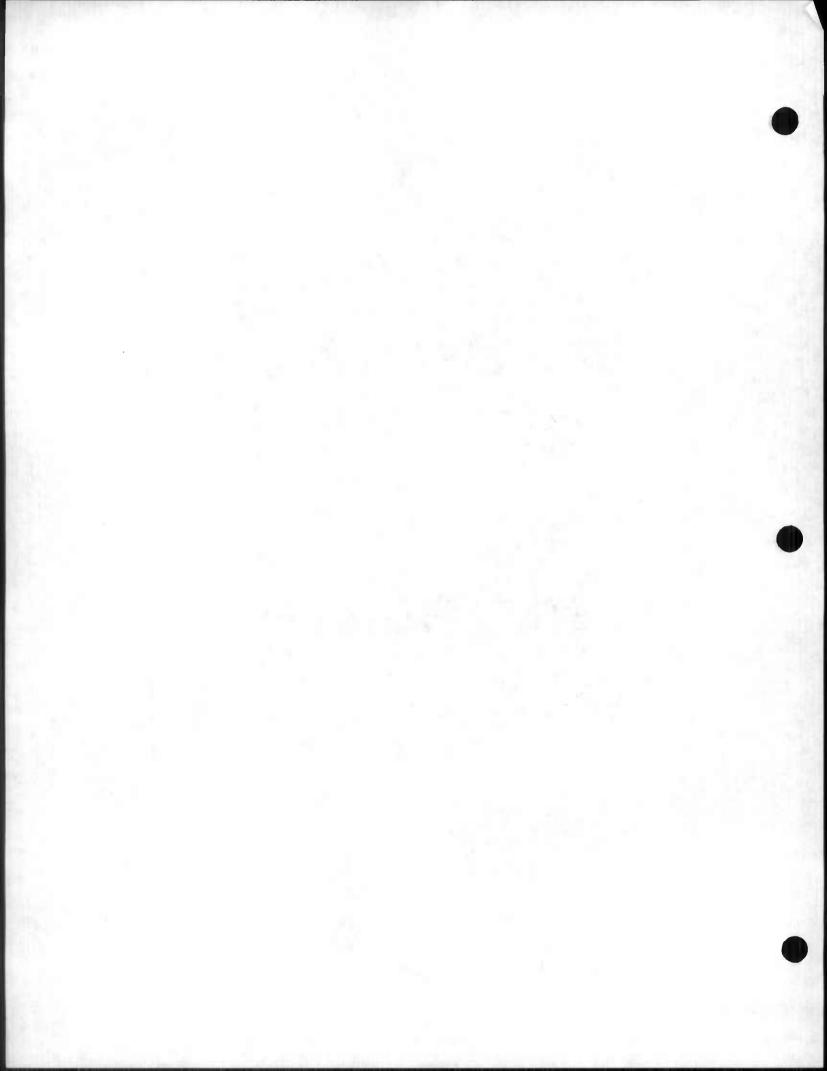
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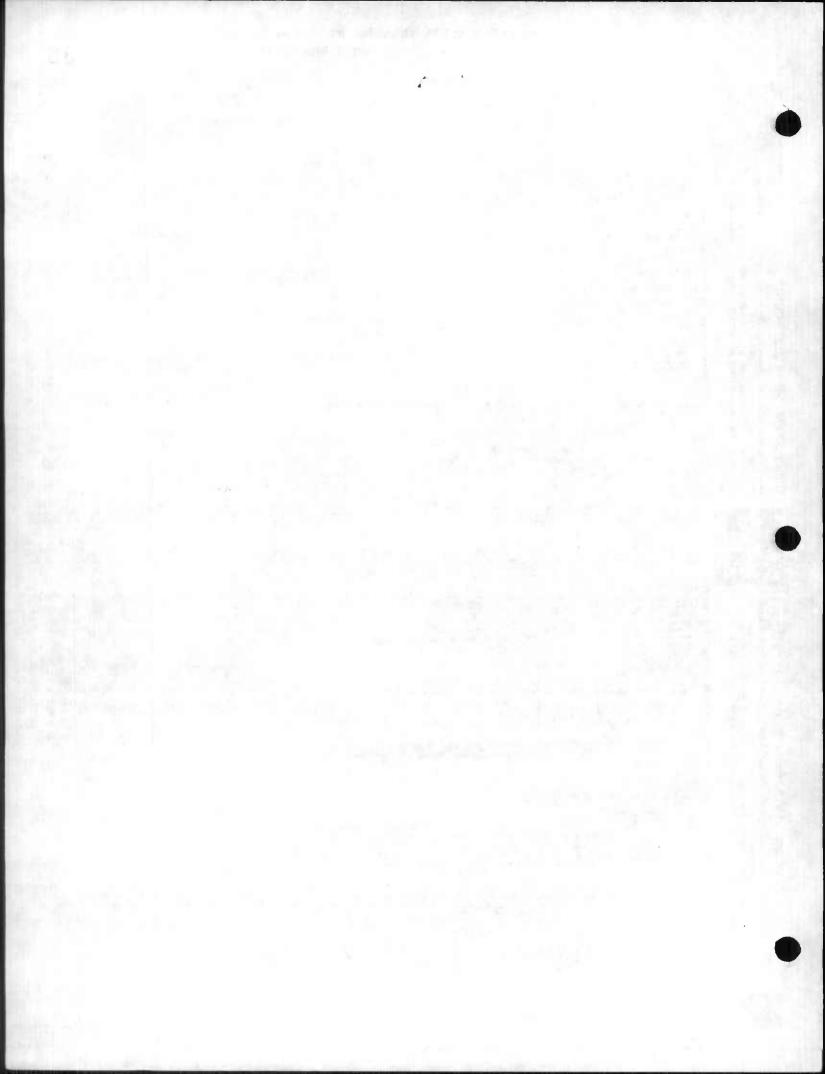
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ended Item#19b	perFHG793 3/15/2001 EW	State of Maryland		nt of Health a te of Death		/giene () () Reg. No.	43638
Physician /Medical	1. Decedent's Neme (First, Middle, Last) RUTH SHIRLE				2. Date of D	31 2	3. Time of Death 1:48AM
Funeral Director	4a Facility Name (If not institution, give s Civista Medic 5. Social Security Number 6. Sex 579-22-7194 Usual Residence of Decedent	al Center	last birthday) If Und Month	LaP ler 1 Year If Under	ym, or Location of Des 1 a t a 24 Hrs. 8. Date of 8 Min. (Month, L	inth (Ay, Year)	of Death arles 9. Birthplace (State or Foreign Country) Washington
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020 us after death us, or thems 25 Examiner must by Furneral		12. Wes Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	S. 13. Was De		gin? (Specify Yes or N n, Puerto Rican, etc.)	Black	American Indian, White, etc. White
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vision of Vital Records, P.O. Box 68760, Attanding Physician: The law requires that the death certificate be and redeath. sector: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the burial direction. To Be Completed by Physician/Medical Elification: To Be Completed by Physician/Medical Elification:	Ceuse (Disease or injury that initiated events resulting in death) Last	Due to (or	es e consequenca c	f):			
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of Vital Records, Physician: The law requires the this certificate has been signeral director, page 2 should be the To Be Completed by:					24a. We	es an autopsy formed?	24b. Were autopsy findings available prior to completion of cause of deeth?
The Late he page	BURNEY WAS				10	Yes 2 No	1 Yes 2 No
f Vital I yelclen: The yelclen: The director, pag	25. Was case referred to medical examiner?	ospital:		Other	e of Deeth (Check only		
sion of \ randing Physic eath. for After this of the funeral direction: To cation: To	1 Yes 2 No 27. Menner of Death 1 Natural 5 Pending 2 Accident investigation	28e. Date of tnjury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury M	28c. tnjury at Work?		sidenca 6 LIOthe how injury occurr	
Division C To the Hospital or Attanding P within 24 hours after death. To the Funeral Director: After ti completely filled in by the funera Medical Certification:	3 Suicide 6 Could not be determined	28e. Placa of Injury - At he building, etc. (Specify	ome, farm, street, fac	ory, office		(Street and Numb own, Stete)	er or Rural Route Number,
DIVI To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by Medical Certifi		Ician: To the best of my knower: On the basis of examinat and manner stated.					
to the within to the comp	29b. Signature and title of certifier 30. Neme and address of person who co	melloted cause of death (from		D 02 ^C	775	29d. Date signed 2 - 6	s (Month, Day, Year) O
State Registrar	Daniel M. Howel 31. Date filed (Month, Day, Year)	M. D. 113	345 Pemb	rooke Sq.	Ste 104	Waldor	f, MD 20603

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Ensure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Jones 29, 12:35 PM Jane 2000 Mary Dec. 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Pocomoke Worcester 4222 Jones Road If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) 5 Social Security Number 7. Age (In yrs. last birthday) 1 M 2 F ~ Yrs. 03/04/1929 Maryland 218-24-3826 Usual Residence of Decedent 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 No Worcester Pocomoke City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21851 4222 Jones Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian 11. Maritaf Status Bleck, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker None Own Home 18 Mother's Name (First Middle Maiden Sumama) 17. Fether's Name (First, Middle, Last) Maurice T. Henderson Lena Betty Byrd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) William H. Jones, Jr./Son 205 7th Street, Pocomoke City, Md. 21851 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removel from State Remson U.M. Cemetery 01/01/2001 Pocomoke City, MD * 4 □ Donation 5 □ Other (Specify) 21 Signeture of Funerel Service Licenses 22. Name and Address of Fecility Hinman Funeral Home Pent: Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest,

Approximate
Approximate
Approximate Approximete Interval Between Onset and Death CARCINOM Immediate Cause (Final disease or condition resulting in death) Due to (or as e consequence of) W ME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of) that initiated events resulting in death) Last Due to (or as e consequence of): IF FEMALE: 23c. tf yes, outcome of pregnency 1 Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnent 3 Ectopic pregnancy in the past 12 i Month Day 1 1 Ye 9 🗌 Ur Part II. Othe

Physician /Medical Examiner

permit. Pages 1 and 2 a Department of Heelth er Importent: if Item 27 is any injury or other treu once.

Physician

/Medical

Examiner

Funeral

Director

"naturel", or Itema 23a or 28a-f show

Pages 1 and 2 should be filed within 72 hours efter deeth vent of Heelih and Mentel Hyglene.
ant: If lean 27 is marked other then "naturel", or Itema 23.
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Directo

Funeral

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Completed

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with the Maryland

Examiner signed by the attending physicien end d be detached for use as the burial-tran Physician/Medical p been sig Completed has t page certificate Be 2 this Certification: After t efter death.

I Director: Af of In by the full à filled In within 24 hours a To the Funeral C

The law requires that the death certificate be executed

Physicien:

Hospital or Attanding

Division of Vital Records, P.O. Box 68760,

1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 □ Pregnent et time of death 5 □ Other (specify) 9 □ Unknown	
Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Pert I.	23e. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 Probebly 4 Unknown
		24e. Was en autopsy performed? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Deeth	(Check only one)
examiner?	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	ne 5 Residence 8 Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Dey Year) Injury Work?	8d. Describe how injury occurred
3 Suicide 6 Could not b		8f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of contine

29d. Date signed (Month, Dey, Yeer) 29c. License number

01-02-01

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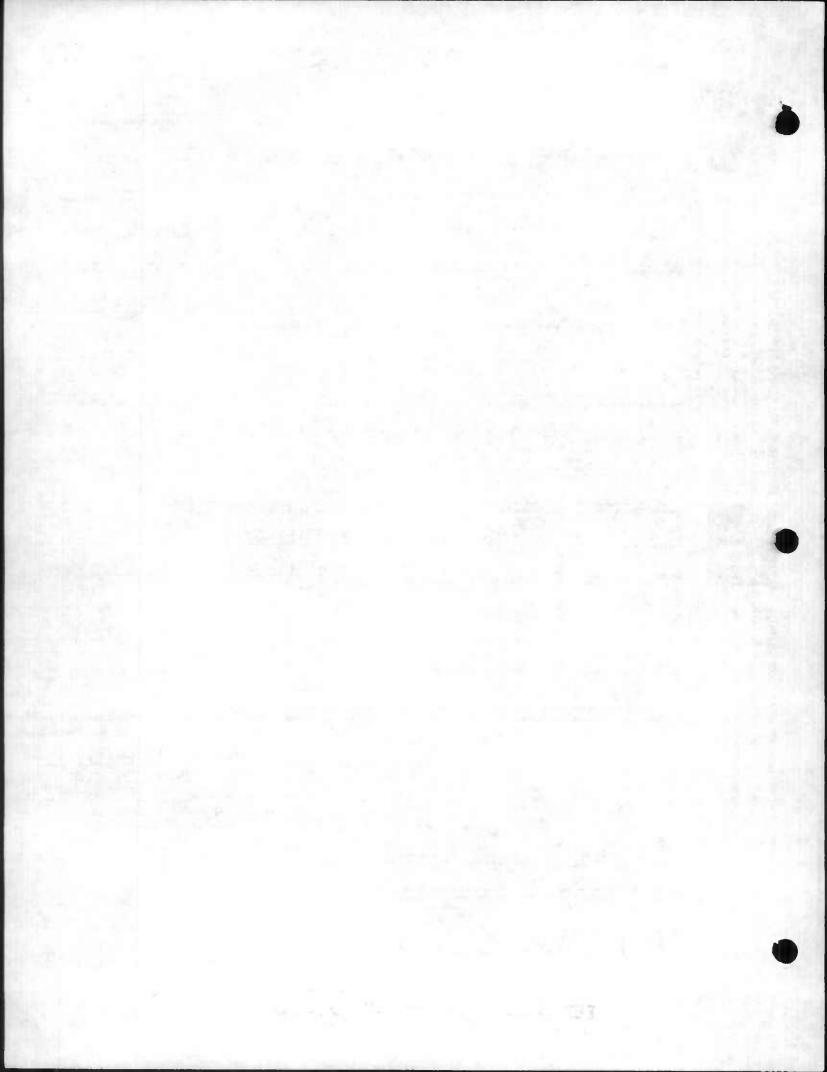
30. Name end doctors of person who completed cause of death (Item 23a) (Type, Print) 100 Eighth St. Santiano MD

21851 Pocomoke, MD

State Registrar

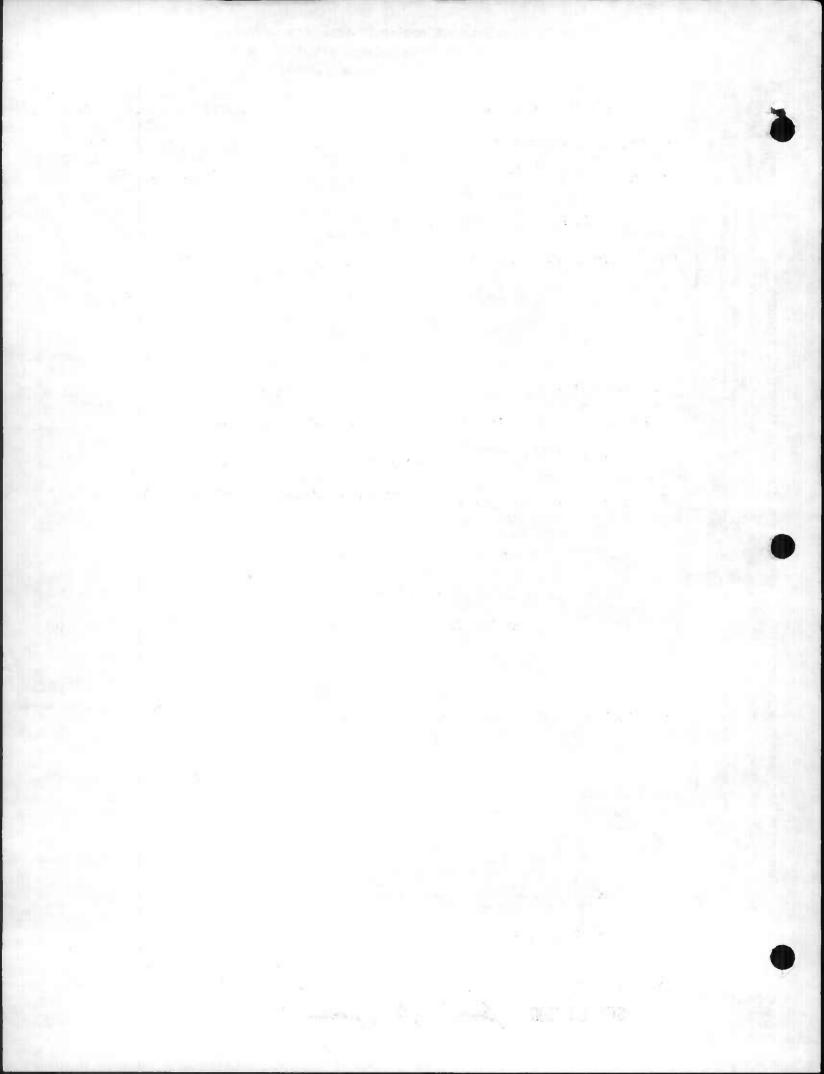
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2001 Registrar's Signature 31. Date filed (Month, Dey, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14 3 5 4 0

					Olulo o.	man	101107				Death		Reg. No.		
	Dharaini		Decedent's Name (First, Middle, Last)									2. Dete of De Month	Death Day Year		3. Tima of Deafh
	Physici /Medi		Inf	ant Fema	ale Muzze	ey .						AUGUST		2000	02:02A.M.
	Examir		As Espility Name (If not institution, give street and symbol)							4	4b. City, Town, or Location of Death 4c. County of Death				
1			MALCOLM GROW MEDICAL CENTER								AMP SPRI	NGS	PRINC	E GE	ORGE'S
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1							If Under 24 Hrs. Hours Min.		Birth Dey, Yeer) 9. Birthplece (State or For Country)			
	Director		unknown Usual Residence of		1□ M 2¬F			Yrs.	MOUITIE	Days		Aug. 29		Mď	muy)
	and **		10a. State	10b. County		10c. City, Town or Location 10d, Insi								10d. Insida City Limits	
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	n 72 hours after deeth with the Maryland "natural", or Hems 23s or 28s-f show solder Examinet must be notified at		Md. 10e. Street and Nun				Waldo	ri	10f. Zip C	ode.			10g. Citizen of V	What Cou	ntov?
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e,	-125		20a. Method of Disp				20b. Place 0	Disposit	ion (Neme	e of		Date	20c. Location -	City or To	own, State
Baltimore,	rt. Peges rtment of rtant: If it				Removel from S		cemete.	ry, crame	itory or oth	er pied		0 1 0000	CT TATION	T MAT	NAT AND
III.			4 ☐ Donation 21. Signature of Fu	5 Other (Spec			LEE CRI	-		A alalas		9-1-2000	AL HOME,		MARYLAND
Ba	Depe Impo any i		21. Signature of Ful	Heral Salvice Lice	risea										0777
					(PER D.V.R.) 6633 OLD ALEXANDERIA FERRY ROA									MD. Z	20735
			23a. Part1. Entar ff shock, or hear	ne disease, or cor rt failure. List onl	nplications that ca y one ceuse on ee	used the ich line.	deeth. Do	not enter	the mode	of dyin	g, such as cardla	or respiratory e	rresf,	1	Approximate Interval Between
	Physician	Ш												i	Onsef and Death
П	/Medical Examiner	П	Immediate Cause (disease or condition	Finel n	CONG	ESTI	VE HEA	ART 1	FAILU	RE				į.	UNKNOWN
в	LAGITITIE		resulting in death) Due to (or as e consequence of):												
	P is	lne			META	METABOLIC ACIDOSIS								1	UNKNOWN
	es that the death certificate be executed igned by the ettending physician and be detached for use as the buriet-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events Due to (or as e consequence of): HYPOXEMIA Dua fo (or as e consequence of):												
30,	se ex	Ü											UNKNOWN		
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	ing p	_			4									-	
Box	tendir tendir or use	an			d										
	he etten	SIC	Part II. Other signific	icant conditions	contributing to dea	ath but n	ot resulting in	n the und	lerlying car	use giv	en in Part I.	23b. Did	tobacco use co	ntribute t	to the causa of death?
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0	£ £ m		27. Manner of Death	1	28a. Date o			Time of		c. Injur		-	how injury occur		·/
0	oth. : Afte	atio	1 X Netural 2 Accident	5 Pending Investigetion		, Day Ye	oar) i	njury	М		Yes 2 □ No				
Division	Attending r deeth. ector: After by the fune	fica	3 Suicide	6 Could not determined	250, MICCO	of Injury	At home, fa	ım, stree	it, factory,	office				ber or Rur	ral Route Number,
á	무용하드	Certification:	4 Homicide		buildin	g, etc. (5	ipecity)					City or 10	wn, Stere)		
	Hospital 24 hours Funerel stely filled		29a. Certifier	12 Certifying P	hysician: To the I	est of m	y knowledge	, death o	ccurred at	t the tin	ne, date end place	, end due to the	ceuse(s) and mo	enner es	stated.
	Ho Fu letel	edicai	(Check only one)	2 Medicai Exa	miner: On the ba and mann	SIS Of OX	eminetion en	d/or inve	stigation, i	n my o	pinion, deeth occu	irred at the time,	dete and place,	and due t	to the cause(s)
	To the Hospital or Att within 24 hours effer d To the Funerel Direct completely filled in by	Me	29b. Signature and	steller designer					29c.	Licens	e number		29d. Date signe	d (Month	Day, Year)
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			20 Name and add	of parameter	nomplated assess	of death	(Itam 07a)	(Time D		540 0 MI		J DEDTY	FEBRUAR		2001
			30. Name and addre								DG/1050 1 EWS AIR :				6600
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	J				/-						-				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year Susan M. Lisek 12-28-2000 6:30pm 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death 2817 Fait Avenue Baltimore If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 09-25-1950 Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Months Hours 1 M 2 F Yrs 219-52-9504 50 MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No n/q Baltimore 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 2817 Fait Avenue 21224 USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. Yes 2V No 11☑ Never Married 2 Married 1 Yes 2√ No Specify: Specify Caucasian 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cleaning Lady St. Casimir's Church 12 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) William R. Lisek, Sr. Evelyn Margaret Burmiester 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Evelyn Lisek 2817 Fait Avenue, Baltimore, MD 21224 20b. Place of Disposition (Name of commetery, crematory or other place)
St. Stanislaus 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-03-0 Baltimore, MD 21. Signature of Funeral Service License 22. Name end Address of Facility Kaczorowski Funeral Home, P.A. 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 1201 Dundalk Avenue, Baltimore, MD 21222.

Approximately 1201 Dundalk Avenue, Baltimore, MD 21222.

Approximately 1201 Dundalk Avenue, Baltimore, MD 21222. Approximate Interval Between Onset and Death retustatic Breast Conco Immediate Ceuse (Finel disease or condition resulting in death) Due to (or as a consequenca of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24e. Was en autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident

Examiner The law requires that the death certificate be axecuted of Vital Records, P.O. Box 68760. a the datanding F a the death. I Director: After of in by the luner Division the Hospital

attending physician and for use as the burial-tran-Physician/Medical signed by the by been sir Completed page 2 Be 10 funeral Certification: edicai To The Composite of the

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Exercises must be notified at

Director MD

Funeral

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Completed

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other

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flem 27 is marked othe eny injury or other traumatic event, bings.

Physician

/Medical

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Attac

24 hours Funeral

Examiner

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Netural

MD

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

170854

29d. Date signed (Month, Day, Year) 2001

8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A Rusebern Dand

301 St PAN PI

Bultonoe MD 21207

State Registra

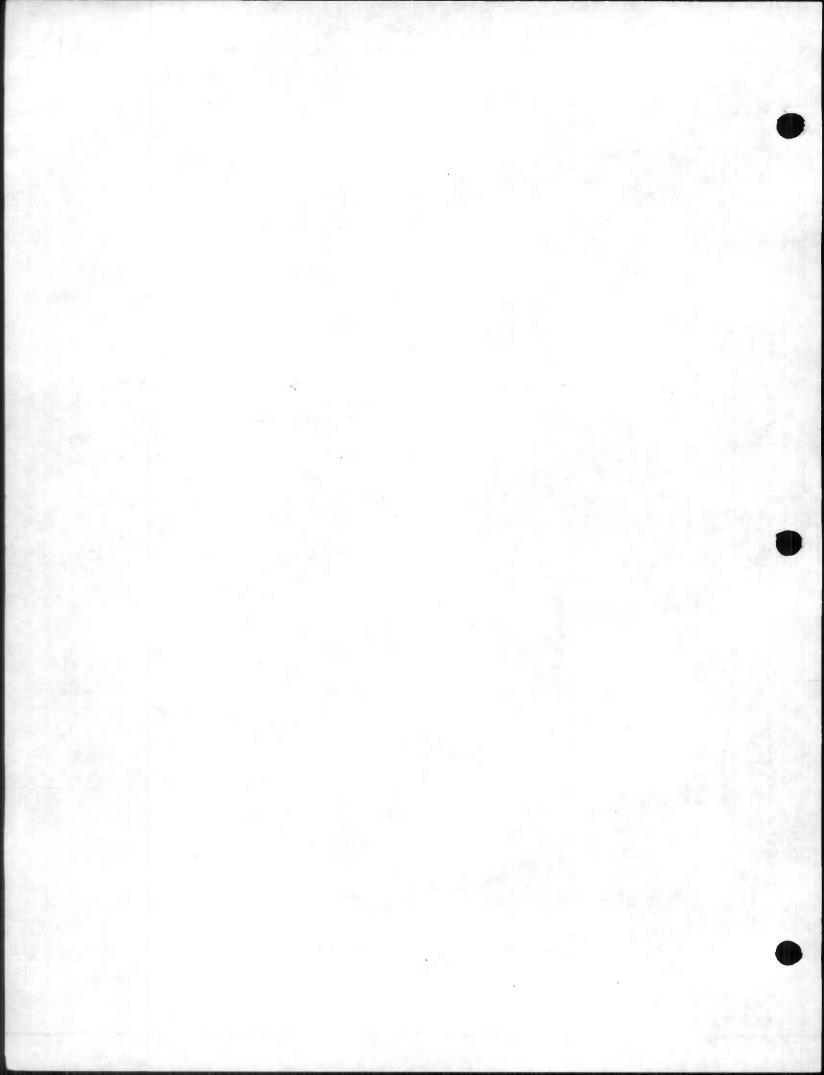
31. Date filed (Month, Day, Year) JAN 1 0 2001

6 Could not be determined

32. Regisfrar's Signature

DHMH 16 Rev 6/95

ORIGINAL



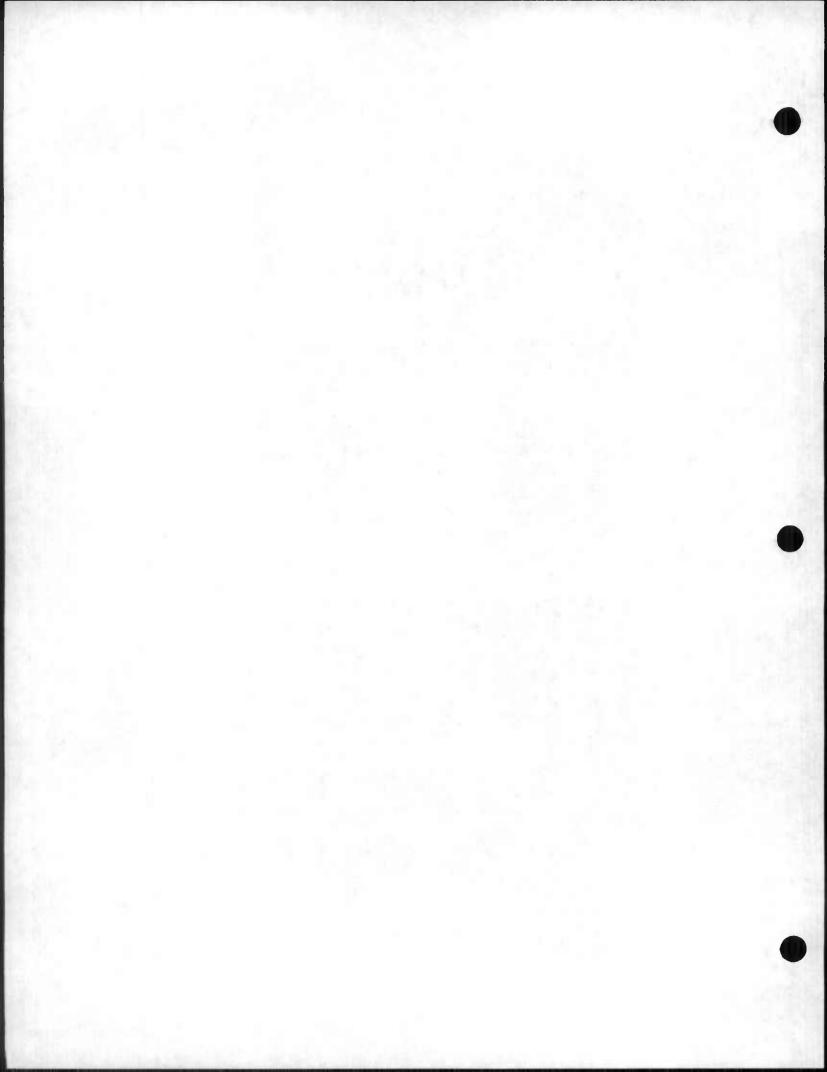
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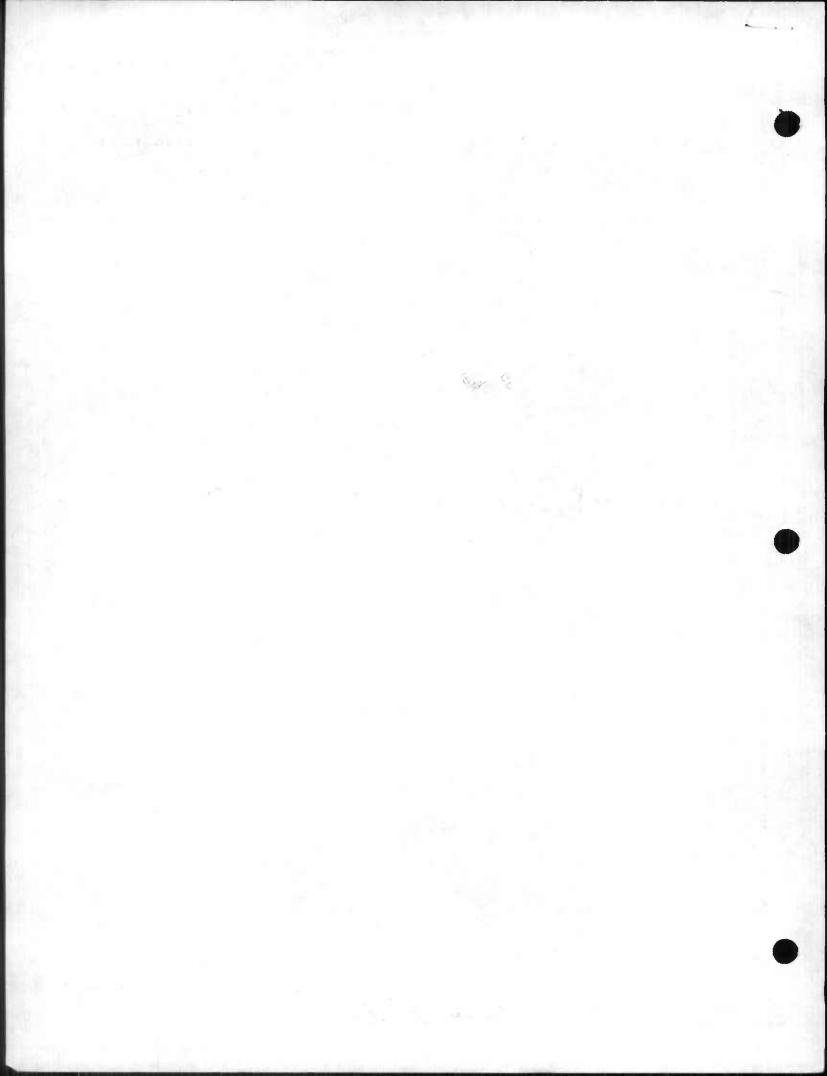
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State of Maryland / Department of Health and Mental Hygiene 00 43643

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Examin		4a Facility Name (If not institution,	give street end	d number)				4	b. City, To	wn, or L	ocation of De	ath	4c. County	of Death		
													Mont	gome	ery	
Funeral			6. Sex	-	yrs. last birthe	Mo	Under 1 Yo	eer eys	If Under Hours	24 Hrs. Min.	8. Date of E (Month, I March	Birth Dey, Ye	ar)	9. Birthp	place (Ste	te or Foreign
Director	п	220-92-3089	1ਊM 2□	85	5 Yr	S.		,-			March	20,	1915			ran
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aryla	7			10c. City, Town or Location Potomac											10d. fnside City Llmits 1 ☐ Yes 2 🕱 No	
28a-f	Director	MD Montgo	omery			40	Of. Zip Cod	da		_		100	Citizen of h	Albert Cour	f Country?	
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Hygid other	Bec	17. Father's Neme (First, Middle, L.	ast)						18. Mothe	er's Nam	me (First, Middle, Maiden Surname)					
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alth e 27 le	end n 27 Ner fr	Dara Farzanega	an	Son	106	00	Burb	ar	ik Di	r. I	Potoma	ac,	MD 2	2085	4	
them of the		20a. Method of Disposition	6		Ob. Place of D				(A)	11-11	Date	20c	. Location -	City or To	own, State)
Page Tr.		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Ottler (50)			Na tio Park	nai	Memo	or	lal	1	/3/01	Fa	lls	Chur	ch.	VA
artm orta		21. Signature of Euneral Service			LULK	22. Na	me and Ad	ddres	s of Facili	1						7482
Ded or you		21. Signature of Euneral Service Ucensee 22. Name and Address of Facility National Fune Lee Highway, Falls Church											ch VA	1 22	042	
	1	23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate fntervel Between		
Physician														fntervel Between Onset end Death		
/Medical		Immediate Cause (Final disease or condition resulting in death) Cerebrovascular Accident a. Due to (or as a consequence of):										mont				hs
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d d ansit	Examiner	Hypertension Sequentially list conditions Due to (or as a consequence of):										1	year	S		
axec in an	EX	Sequentially list conditions, if any, leading to immediate ceuse. Enter Undertying Cause (Disease or injury														
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in physical as the	Ved	resulting in death) Last														
eath cert ettendin I for use			d	d												
death e ette ed for	Physician	Part II. Other significant condition	s contributing	to death but no	t resulting in t	he under	fvina ceus	e div	en in Part	l.	23b. D	d toba	cco use co	ntributs t	o the cau	se of death?
that the detected	hys						,				1	Yes	2□ No	3 □ Pro	bably	4⊠ Unknowr
5 00	by P															
v requires been sign should be	8										24a. W			24b. W	ere autop	sy findings
20 00	Completed							_		_	pe	rformed	,,	C	ompletion death?	of cause
0 - 5	HIG.										11	Yes	2) No		□Yes	2□ No
		25. Was cese referred to medical						-	06 Dina	a of Doo	th (Check on	-	2,0110		_ 100	20140
	o Be	examiner? 1 Yea 2 No	Hospital:	1 Inpatient	2□ EB/Outo	etient 2	BD DOA	Oth	or.		ome 5 Re		6 DO#	or /Snaci	i6/)	
	-	27. Manner of Death		Date of Injury Month, Dey Yea		ne of	28c.	Injun		araing ri	28d. Descrit				'77	
ding th.	tloi	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga		Month, Dey Yea	ar) Inji				k7 Yes 2□	No						
or Attending after death. Director: After d in by the fune	flee	3 ☐ Sulcide 6 ☐ Could no	of be 28e. P	Place of Injury - puilding, etc. (S)	At home, fam	n, street,	factory, of	fice			28f. Location			ber or Rur	al Route I	Vum <i>ber</i> ,
2 4 5 5	Certification:	4 Homicide	Ь	ouilding, etc. (S	pecify)						City or	rown, S	1010)			
To the Hospital within 24 hours a To the Funeral Completely filled		29a. Certifier 1 Certifying	Physician: To	the best of my	knowledge, d	death occ	curred at th	ne tin	ne, date ar	nd place,	and due to ti	ne ceus	e(s) and m	anner as a	stated.	
P Fu	edicai	(Check only 2 Medical E	xaminer: On the	ne basis of exa menner steled.	mination and/	or Investi	gation, in r	my o	pinlon, dea	ath occur	red at the tim	e, date	and place,	and due t	to the cau	se(s)
within 2 To the comple	M	29b. Signeture and Aitle of Course	7				29c. Lie	cens	e number			29d.	Date signe	d (Month,	Day, Yes	nr)
		- XOL	In.	111		29c. License number D35792						29d. Date signed (Month, Day, Year) December 30, 200			2000	
3		30 Name and address of sare	to complete d	names of door	/Itam 22a) /T	una Drint									-	
		30. Name and address of person-w Swaroop G. Ra						D~	. # 5	504	Pogl		110	MD	2005	2
		31. Date filed (Month, Dey, Year)		2. Registrar's S		-	4	וע	• #=	104,	KOCK	V L	rie,	LID .	2000	2
Stat		4844 4 -	2001	Bener	w A		don	1/2								

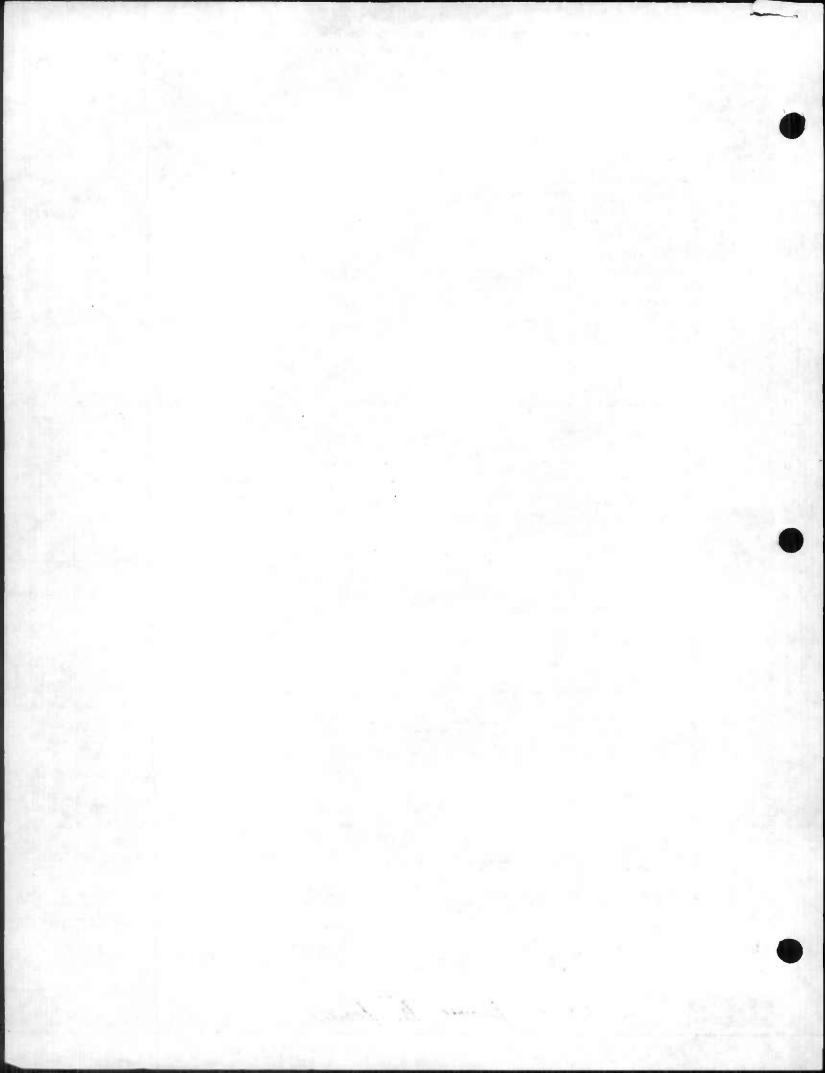


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sician	Ruth		N	1.			Raws	on	Month Decembe	r 30 20	Year 000 1	2:45 PM	
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ral or	5. Sociel Security N 124-20-7	lumber 6. S	3. Sax 1 M 2 TF 7. Age (In yrs. last birth 87 Y			If Under 1 Year If Under 24 Hrs Months Deys Hours Min			. (Month, De	th sy, Year) .0, 1913	9. Birthplaca (State or Foreign Country) 3 Iowa		1
	Usuel Residence o	Decedant 10b, County		10c Ci	by Town or Lo	ocation					104 le	nside City Limits	
rai Director	10a. 31616	The state of the s	10c. City, Town or Location									Yes 2 No	
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						101. 2		850					
919	11. Maritel Status	more Road	12. Was Deced	ent Ever in II	IS 13 1	Was Dare			Specify Yas or No	United	- American In		
by Funeral		ied 2 Married 4 Divorced	Armed Ford 1 Yes 2 If Yes, Give Year or Del	es? PNo		If Yes, spo		Specify:	Specify Yas or No rto Rican, etc.)	Specify:	white, etc.		
		15. Decedent's Ed	ducation		16a. Dece	dent's Usi	uel Occup	etion		16b. Kind of Bu		у	
Completed	(Spec	only highest gre	College (1~	for 5 _A)	life.	DO NOT	ork done use retired	during most of wi	orking				
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Be	17. Fathar's Name	(First, Middle, Last,					1	18. Mother's Ne	eme (First, Middle	, Maiden Sumem			
To	Fred	J. N	Miller					Lilliar	1		Be1kn	ар	
	19e. Informant's N	eme/Relationship (Type, Print)							er, City or Town,	Stete, Zip Cod	le)	
	Jean Raw	son/Daugh	nter					Court,	Rockvil:	le, MD 2	20850		
nt: If Item ry or othe		position Cremetion 3 5 Other (Specif		lete	20b. Pleca of Disposition (Nema of					Dete 200. Location - City or Town, Stete 2001 Beltsville, MD			
		ineral Service Licer		CII						ral & Cremation Serving, MD 20910			- 69
	1	1 . 11	3/	,	Si	tephe	en D.	Lohrman	lver Spr	ing. MD	20910		
an al	Immediate Cause							ig, such as cardi	ac or respiretory e	errest,	Ons	proximate rivel Between set end Death	
er	disease or condition resulting in death) Due to (or es e consequence of):												
Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): C								1 t	e va			
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lan													
Physician/M	Part II. Other signi	licant conditions of	ontributing to dea	th but not res	sulting in the u	inderlying	cause giv	en in Pert I.		tobacco uae cor			
by	Insulin	Dependen	t Diabet	es Mel	litis				- 1	Yes 2 No			νn
Completed			177							24a. Wes an eutopsy performed?		tb. Were autopsy findings available prior to completion of cause of death?	
Con									10	Yas 2 No	1 ☐ Ye	s 2∏ No	
Be	25. Wes case references	red to medical							eeth (Check only				
10	1 Yas 2	No	Hospital: 1 ☐ In	patiant 2	ER/Outpetie	nt 3 🗆 🖸	Ott	ner: 4 Nursing	Homa 5□Res	idence 6 100th	or (Specify)	ssisted	
	27. Menner of Deal 1 Netural 2 Accident	h 5 Pending invastigetio		Injury , Dey Year)	28b. Tima o Injury	of M	28c. Injui Wor 1 🗆			28d. Describe how injury occurre			
Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)									(Street end Numb own, Stete)	er or Rural Ro	ute Number,	
edical	29a. Certifier (Check only one)	1 Certifying Pt 2 Medicat Exar		is of examine						cause(s) end me , dete end place, a			
Medical Certification	29b. Signeture end	title of certifier	Manager 1			2	9c. Licens	e number		29d. Dete signed	(Month, Day,	Year)	
	D44157 Janu									Lanuary	ary 05, 2001		
	30 Name and add	pes of personal	completed cause	of death (Ital	m 23e) (Tuno	Print)		744137		January	03, 20	01	
	30. Nama and add	ess of persor who						4,500	20851	January	05, 20		

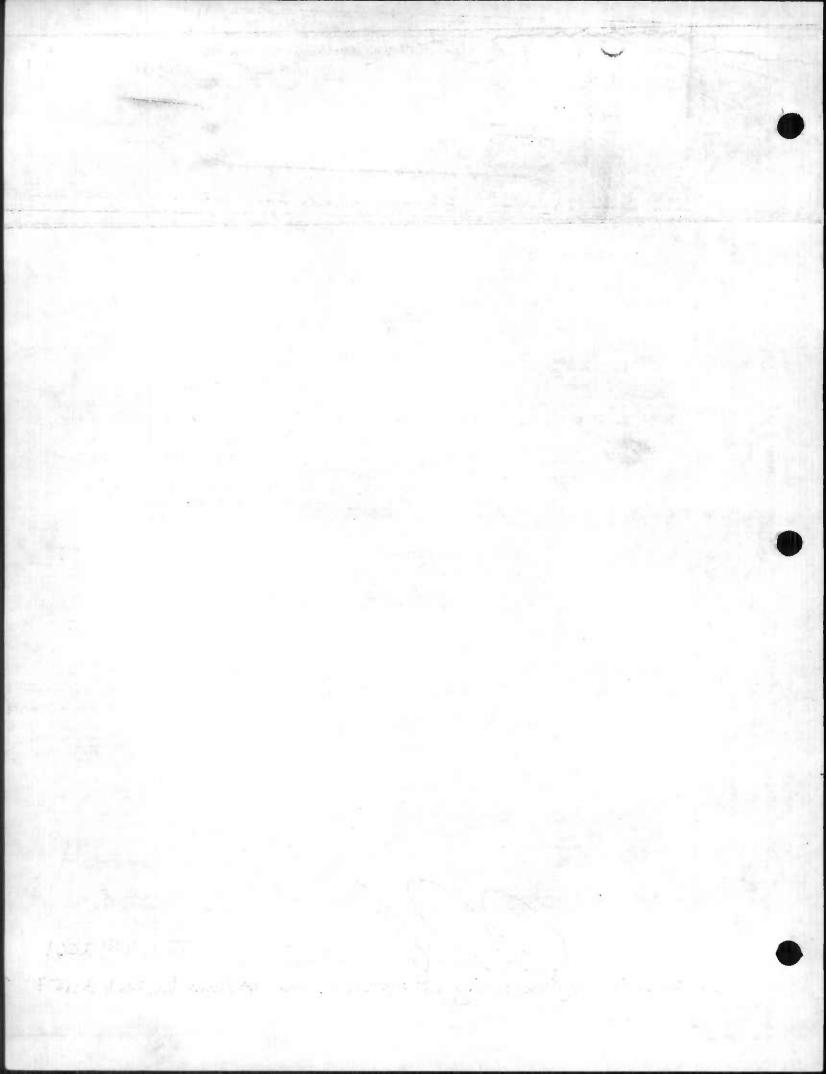
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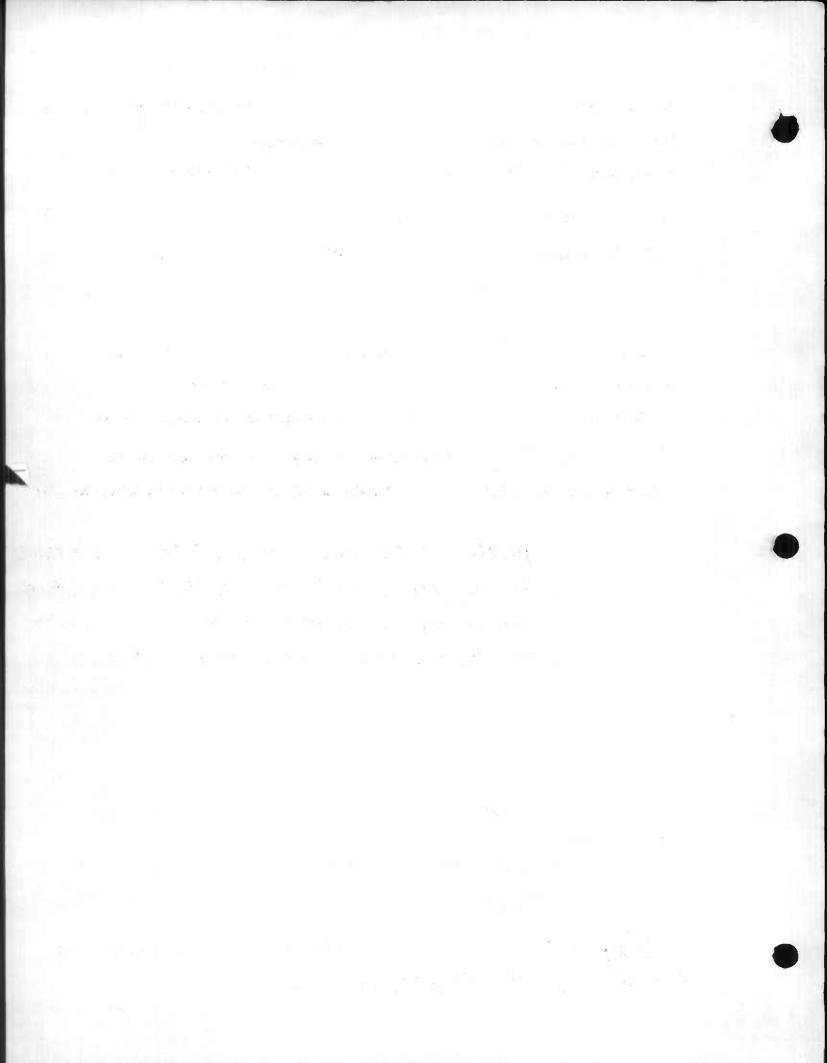
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	1. Decedent's Name (First, Middle, La	ist)						2. Dete of D Month		Year	3. Time of De
ysician tedical	Dorothea	Edna	Stephe	enson				Dec.) Total	5:20 PM
fedical aminer	4a Facility Name (If not institution, give	re street and number)		-1-1-1	4	b. City, To	wn, or Lo	cation of Dea	th 4c. Count	y of Death	h
	Carroll Lutheran	Village			1	Westm	inst	er	Carrol	.1	
	5. Social Security Number 6. S		(In yrs. last birth		or 1 Yeer	If Under		8. Date of B	irth	9. Birth	nplace (State or Fountry)
	226-44-9109	1 M 2 KF	89 Y	rs. Months	Days	Hours	Min.	Sep. 3	,1911	Miss	
	Usual Residence of Decedent										
	10a. State 10b. County		10c. City, Town	or Location							10d. Inside City L
tor	Maryland Carroll		Westmin	ster							1 Yes 2[
řě	10e. Street and Number			10f. Zi	ip Code				10g. Citizen of	What Col	untry?
Funeral Director	205 St. Mark Way	# 501			2115	8			USA		
90	11. Mentel Stetus	12. Was Decedent Ev	ver in U,S.	13. Wes Dece	edent of H	lispanic Ori	gin? (Spe	cify Yes or N			ricen Indian,
Ē	1 Never Merried 2 Merried	Armed Forces? 1 ☐ Yes 2 ☒ No					i, Puerto	Rican, etc.)		ick, White	
þ	3 √ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □ Yes	ZI No	Specify:			Specia	y: Whi	te
20	15. Decedent's E	ducation	16a. l	Decedent's Usu	ual Occup	ation			16b. Kind of B	Businass/1	Induatry
e d	(Specify only highest gra		,	Decedent's Usu (Give kind of wo life. DO NOT u	ork done o use retired	duning mos	t of worki	ng			
Completed	Elementary/Secondary (0-12)	College (1-4or 5+	Cle	rk					Nat'1. S	Secur	ity Agen
0	17. Fether's Name (First, Middle, Last)				18. Mothe	er's Name	(First, Middl	e, Meiden Sumai	me)	
o Be	Thomas D. Hanna					Eliz	abet	h Bran	aird		
۳	19a. Informant'a Name/Relationship ((Type Print)	19b	Meiling Addres	s (Street	and Numbe	er or Rure	I Route Num	ber, City or Town	State, Z	in Code)
	Ralph T. Stephens								e, Maryl		
	20a. Method of Disposition		20b. Place of	Disposition (Na	ame of			Date	20c. Location	- City or	Town, State
	1 € Burial 2 □ Cremetion 3 □		cemetery	, cremetory or	other place		1				
	4 □ Donation 5 □ Other (Special		Nation	al Memo				02/01	Falls Cl	nurch	ı, Virgir
	21. Signature of Funeral Service Lice	nsee		Money	and Addres	ss of Facilit	Vier	na Fu	neral Ho	me.	Inc.
	SALUX I) os	11/2001		171 W	Мат	le As	zenue	-Vien	na, Va.	2218	0
	23a. Part1. Exter the disease, or comshock, or heart failure. List only	plications that caused the	he death. Do no	ot enter the mo	de of dyin	ng, such as	cardiac o	or respiratory	arrest,	1	Approximate Interval Between
	SHOOK, OF HEART TAILUTE. EIST ONLY	One cause on each line									Onset and Dea
	Immediate Cause (Final										
		Aspirati	ion Pnei	monia						1	5 days
	disease or condition resulting in death)	* Aspirati			1.					1	5 days
Jer	disease or condition	8	ion Pneu):					1	5 days
miner	disease or condition resulting in death)	b	ue to (or as a co	onsequence of)						1	5 days
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cal Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	b	due to (or as a co	onsequence of)):						5 days
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n/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	b	due to (or as a co	onsequence of)):						5 days
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					C	ertifica	te of	Death		Reg. P) 4	3040
Physician		e (First, Middle, La:	st)						2. Date of D Month	Dey	Year	3. Time of Deeth
/Medical	Shirley								Decemb		2000	1:36 pm
Examiner		f not institution, give		ber)				4b. City, Town, o	r Location of Dee	th 4c. Count	ly of Deeth	
	Good Sat	naritan H			In a to the total or	If I Ind	er 1 Year	Baltimo:		inth	O Birth	Inna (State on Femilia
Funeral Director	218-32-3	3228	ex □M 2☐xF	Age (In yrs.		Month				1936	Coun	lace (Stete or Foreigr try) Land
land w	10a. State	10b. County		10c. C	ty, Town o	r Location					1	0d. Inside City Limits
the Marylar 28a-f show notified at	MD	Baltimore	2		Balt	imore						1 ☐ Yes 2 No
death with the Manyland rms 23a or 28a-f show rms to notified at neral Director	10e. Street and Nu	mber				10f. 2	ip Code			10g. Citizen of	Whet Coun	try?
23a c	8549 Wat	er Oak Aver	nue				212	34		USA		
urs efter Mr. or its marring by Fu		ied 2 Merried 4 Divorced	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Da	es? No	J,S.			Hispanic Origin? en, Mexicen, Put Specify:	(Specify Yes or Nerto Rican, etc.)	lo- 14. Ra Ble Speci	ice - Americ ack, White, ify: Whi	etc.
natural'.	(Spec	15. Decedent's Ed	lucation de completed)		16e. De	ecedent's Us	uel Occu	pation during most of w	rorking	16b. Kind of E	Business/Ind	tustry
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day William Henry Nussle, Sr. October 11:08 P M 8, 2000 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 1545 Hollingsworth Road Harford Joppa If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Data of Birth (Month, Day, Year) Aug. 27, 192 Birthplace (Steta or Foreign Country)
 Mary Land Months Days Hours 13M 20F 206-14-3162 75 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Harford Joppa 1 Yas 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1545 Hollingsworth Road 21085 USA 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes 2 No If Yes, Give 1943–46 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - Amarican Indian, 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15, Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Home Construction 12 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) John Jacob Nussle, Sr. Anna Johanna Dietz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Pearl M. Nussle / Wife 1545 Hollingsworth Road, Joppa, Maryland 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Suriat 2 Cremation 3 Removel from State Bel Air Mermorial Gardens 10/12/2000 Bel Air, Maryland * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licenses Stephen A. Hughes per DVR 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Daeth Immediate Cause (Finat disease or condition resulting in death) months Lung Cancer Due to (or as a consequence of): Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of dalivery 3 ☐Ectopic pregnency Month Day 4 Pregnant at time of deeth 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probebly 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24e. Was an autopsy performed? 2₩ No 1 Yes 28. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☑ Residence 8 ☐ Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA

Physician /Medical Examiner

certificate be executed

Box 68760

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Records,

Division of Vitai

permit. Peges 1 and 2 sh Depertment of Health and Important: If Itam 27 Is m any Injury or other traum QDGs.

Physician

/Medical

Examiner

Director

Funeral

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Funeral

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with the Maryland

is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. At the terma 23a or 28a-f show other traumatic swart, the Marylan Exerties mainton notified at other traumatic swart, the Marylan Exerties mainton notified at

Baitimore, Maryland 21215-0036

Examine the attending physicien end ned for use as the buriel-transit iclan/Medical as the ate has been signed by the page 2 should be deteched à Completed funeral director, To the Hospital or Attending Pt within 24 hours efter death.
To the Funeral Director: Alter the commission filled in by the funera Certification:

certificate has

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After

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death

28a. Date of Injury (Month, Day Yeer) investigation

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28d. Describe how injury occurred

29a. Certifier (Check only one)

31. Date filed (Month)

1 SNatural

2 Accident 3 Suicide

4 - Homicide

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certified

5 Pending

6 Could not be determined

29d. Date signed (Month, Day, Yeer)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 Schilling Road, Suite 1 Mark A. Lamos, M.D. Hunt Valley, MD 21031

State Registrar

DHMH 17 Rev 1/2001

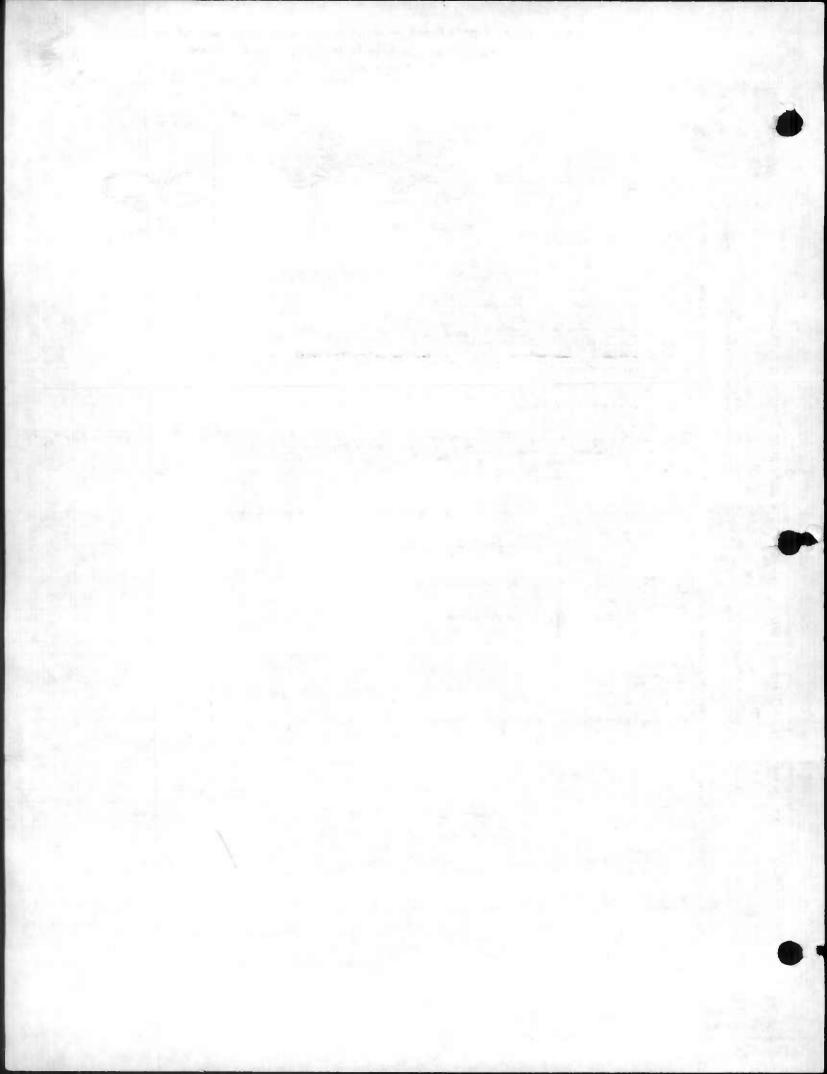
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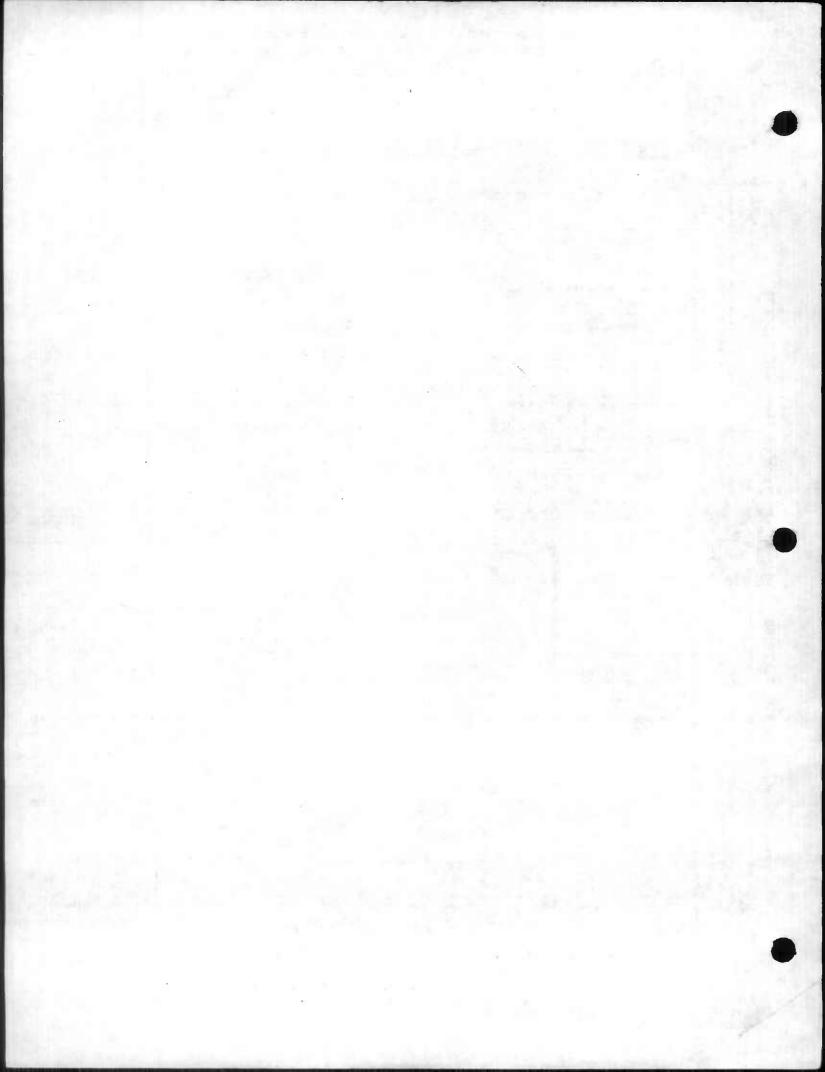
32. Registrag's Signature



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Baltimore, Maryland 21215-0036

Box 68760

Division of Vitai Records,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM 1,17,19a,23a,27,29d per ME G796 061301 SS Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Day Month Year **Physician** Isaiah John Gerstel Isaiah John Certsel 0536 a.m. DECEMBER 20, 2000 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (Il not institution, give street end number) 4c. County of Death Examiner BALTIMORE JOHNS HOPKINS BAYVIEW N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dev. May 29 7. Age (In vrs. last birthdev) Birthplece (State or Foreign Country) **Funeral** Months Deys 15 M 20 F Hours 6 218-57-6480 Maryland Director Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? iner mast be n 953 N. Wolfe Street 21205 USA Funeral 14. Rece - American Indien, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus than "natural", or iten the Medical Examiner 1 Never Merried 2 Married 1 Yes 2 No Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Hygiene. N/A Infant Child. 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Pages 1 and 2 should be filtered of tearts if lean 27 is mericed off dury or other traumetic even 88 Guy E. Gertsel Gerstel Dolabriel Herst 10 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Guy E. Gerstel (Father) 6219 Marlora Road Baltimore, Maryland 21239 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removel from Stete
4 Donetion 5 Other (Specify) Dulaney Valley Mem Pk 12/23/00 Timonium, MD 22. Name and Address of Facility Caple Funeral Service 21. Signeture of Funeral Service Licenses 5502 Winner Ave. Baltimore, Maryland 21215 23e. Pert Lenter the disease, of complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death Physician Immediete Ceuse (Final disease or condition resulting in deeth) /Madical a SUDDEN INFANT DEATH WITH FOCAL ACUTE BRONCHOPNEUMONIA E2aminor Due to (or as e consequence of): Examine physician and s the burial-transit certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or es e consequence of): 80 attending USB detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed by be deta þ 24b. Were eutopsy findings available prior to completion of cause of death? should 1 24a. Was en eutopsy performed? Completed After this certificate has funeral director, page 2: 2□ No 25. Wes case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Death Lo 28e. Dete of injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28c. Injury at Work? Attending 5 ☐ Pending investigation 1 Netural 2 ☐ Accident death. 1 Yes 2 No Director: J 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) Hospital or At 24 hours after of 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 29e. Certifier 1 Certifying Physician: To the bast of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) and manner steted. edical 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) O.C.M.E. December 20, 2000 crow) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 THEDDORE

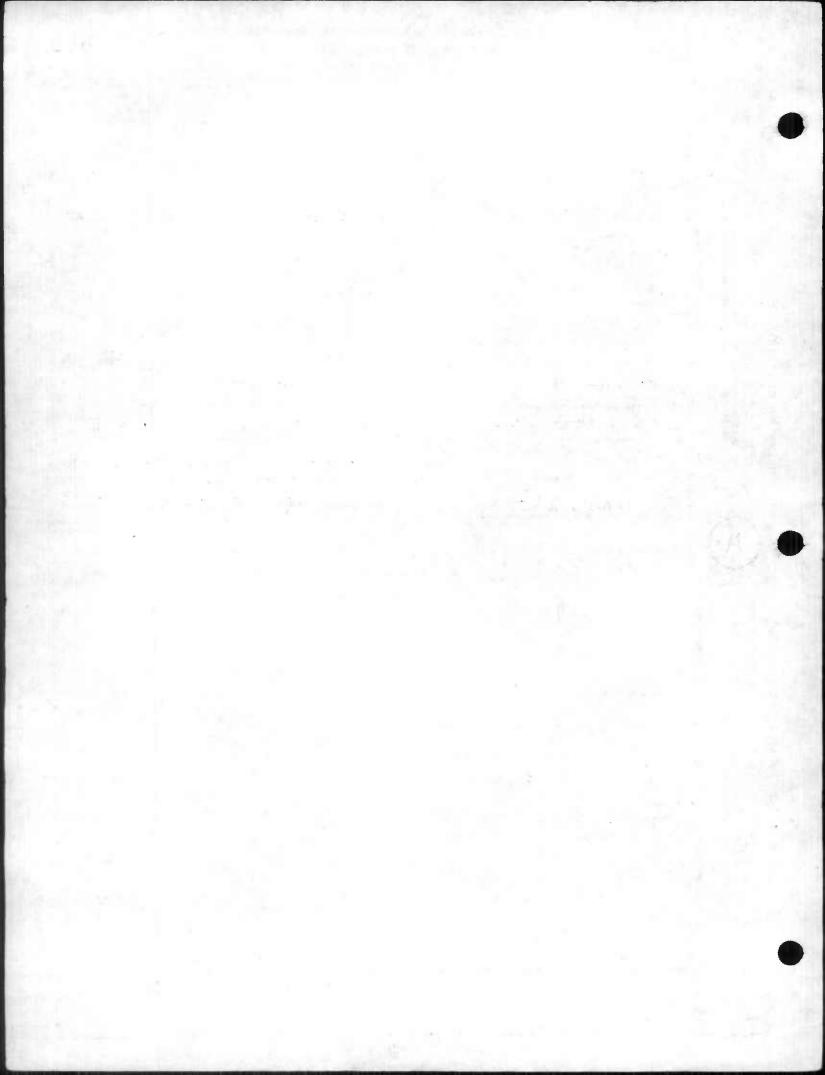
State Registrar

31. Dete filed (Month, Day, Year)

32. Registrer's Signeture 22 never

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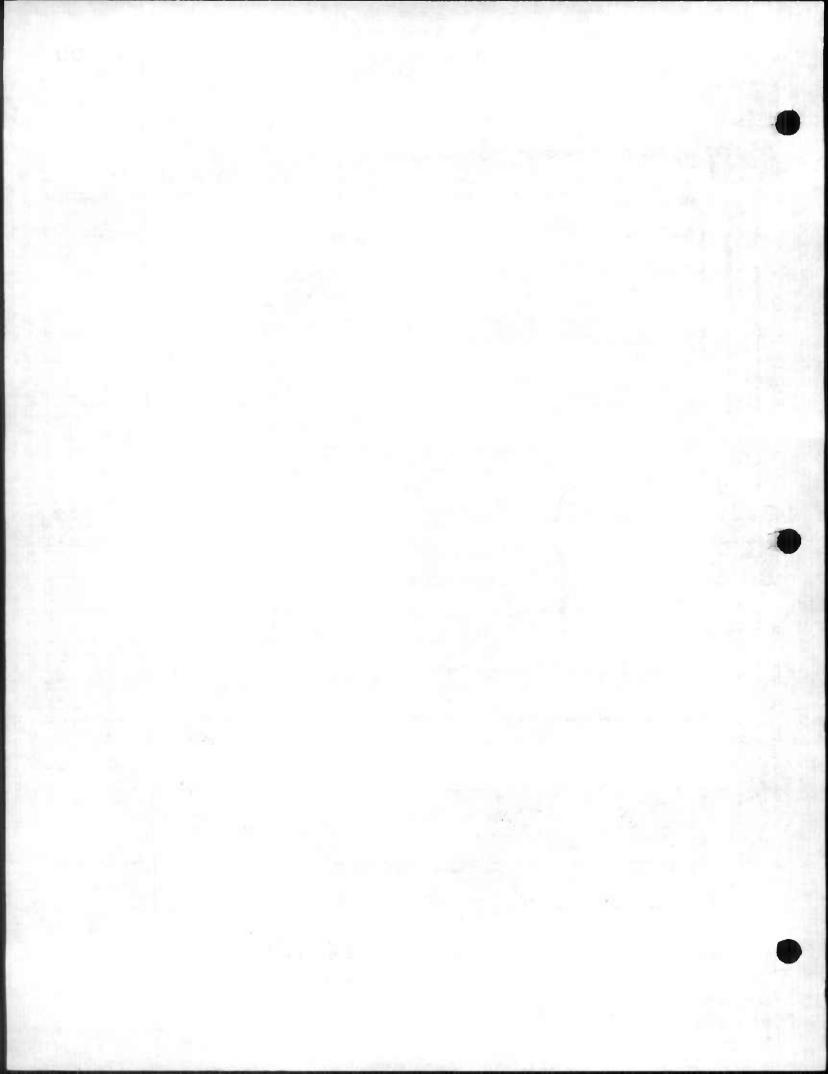
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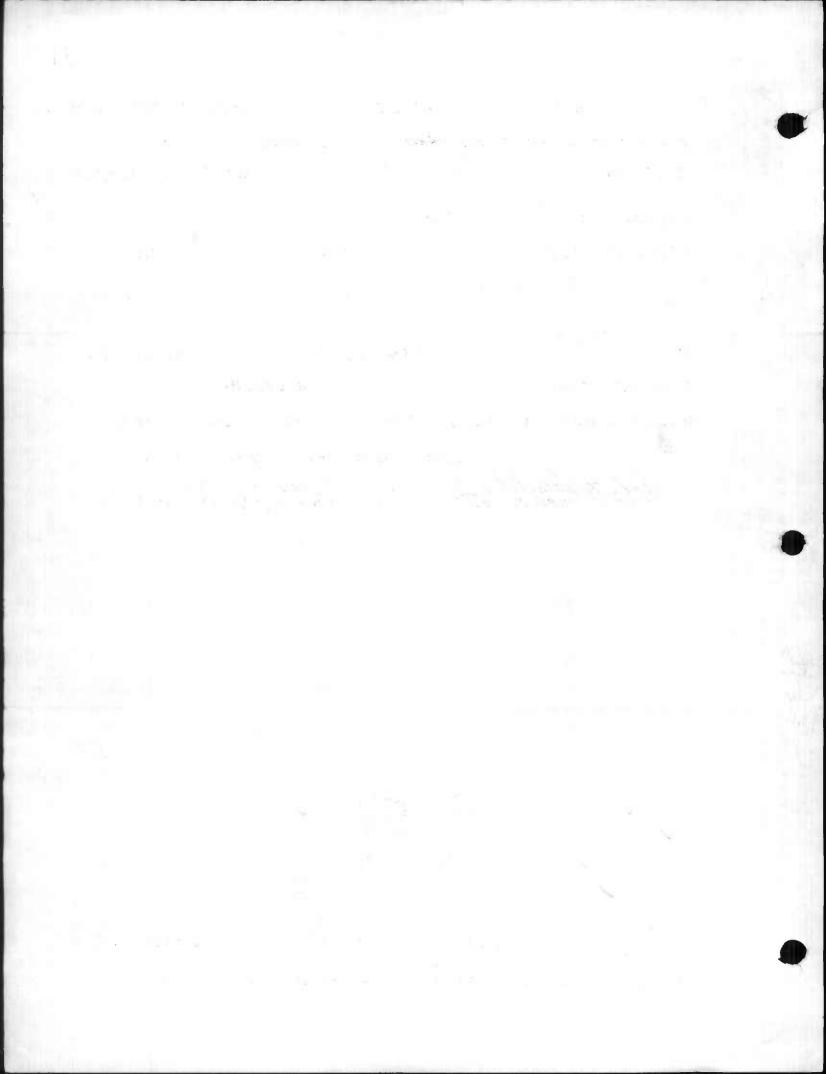
		For State Registrar	State of	Marylar		artmen rtificat			nd Mei		g. No.	43	650
Physicia /Medic		1. Decedent's Name (First, Middle, Candace E. St								Date of Death Month 'ebruar	Dey	Year 2000	3. Time of Dear
Examin		4e. Facility Name (If not institution, g PENINSULA REG	ive street and numb	ber)	CENTER	4b. City,	Town, or I	Location of I LISBUI	Deeth RY		4c. Coun	VICOMI	СО
Funeral Director		221-42-8852	. Sex 7. 1 □ M 2 □ F	. Age (In yrs. 42	lest birthday) Yrs.	If Under Months	1 Year Days	Hours	Min.	Date of Birth (Month, Dey, 22/57	Year)	9. Birthp Cour Mary	lace (State or For try) land
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or 28a-f	Direct	10e. Street and Number				10f. Zip				10	g. Citizen o	Whet Cour	itry?
al', or Itama 23 septiment mus	by Funeral Director	723 olivia Street 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	If Vac Give	es?	S 10 10 3	1			n? (Specif Puerto Ric	y Yes or No- ean, etc.)	BI	lack, White,	
one. than *na	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 1 2	Education		16a. Deced (Give life.	DO NOT us	rk done du se retired)	urina most o	of working	1			THE STATE
d of	To Be Co	17. Father's Name (First, Middle, La Oscar E. Elzey, J			USA I	nspect	-11			First, Middle, Monnelly H	leiden Sume	Citizen of Whet Cou USA 14. Race - Amenin Black, White, Specify: B. 5. Kind of Business/In Federal Gove den Sumeme) pkins ty or Town, State, Zij	rnment
am 27 thar t		19e. Informant's Name/Relationship Kendra Renee Hotten 20a. Method of Disposition 1	- Daughter	20b.		Poplar esition (Nar	Stree	et, Fru		, MD 218	26	n - City or To	
Department of I		21. Signature of Funeral Service Lie Bennie Smith			22	2. Name en	nd Address	s of Facility			. Isabe	alla St	reet
S G	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Einter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	r as a consec r as e consec r as a consec	quence of):								
	Completed by Physician/Medic	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		th 2 Fet	al death 3	Ectopic pr						Date of delive	ory Day Year
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pege	Complete									24a. Was ar eutopsy perform 1 Yes 2	1	o. Were euto prior to co death? 1 \(\sum \) Yes	psy findings avail mpletion of cause 2 No
After this certificance of the control of the contr	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner ol Death 1 Natural 5 Pending investiga	28a. Date of (Month)		ER/Outpatier 28b. Time o Injury		Other	r. 4 🗆 Nurs	ing Home	5 Reside	nce 6 🗆 O		γ)
within 24 hours effer death. To the Funaral Director: After completely filled in by the fune.	Certification;	3 Suicide 6 Could no 4 Homicide determin	288. Place 0	I Injury - At h g, etc. <i>(Speci</i>	nome, farm, str	reet, factory	y, office		281	Location (Str City or Town		mber or Rure	l Route Number,
in 24 hour the Funer pletely fill	Medical	(Check only 2 Medical Ex	Physician: To the baseminer: On the baseminer	est of my in sis of examin	ovledge, deat ation and/or in	vestigation	, in my op	inion, death	place, and occurred	at the time, da	te and place	e, and due to	the cause(s)
ToT	Z	29b Signature and title of affilier	11	1	W		License	number 27	8	29		hed (Month,	
		100		-	. –		リイイ	111	0		1-	1-1-	

DHMH 17 Rev 1/2001



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al		Chestertown Nursing 5. Social Security Number 6.		ge (in yrs. las	t birthday) If Und	der 1 Year	Chestert	8. Dete of Bi	Kent		ece (Stete or Foreigny)
or .		214-03-5806	1□M 2 X F	85	Yrs. Month	ns Deys	Hours Min	March 16	9. Year) 1915	Mary	land
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rec	9	10e. Street end Number			-	Zip Code			10g. Citizen of \	Whet Count	ry?
by Funeral Director	<u>a</u>	12189 Coopers La	ne			216	578		U.	S.A.	
by Funeral Ofrector		11. Maritel Status 1 ☐ Never Married 2 ☐ Married 3 ☎ Widowed 4 ☐ Divorced	12. Wes Decedent Armed Forces' 1 Yes 2 If Yes, Give Yeer or Detes:	?		cedent of F pecify Cub 2 X No	Hispenic Origin? (Sen, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		e - America ck, White, e /: Whit	tc.
fed	Del	15. Decedent's (Specify only highest g	Education	1	16e. Decedent's Us	suel Occup	petton	a de la ca	16b. Kind of B	usiness/Indu	ustry
Completed	mple.	Elementery/Secondery (0-12)	College (1-4or				during most of wo	пкту			
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o Be	Ď	James Roger Hinm	•					fae Nels		10)	
2	- -	19e. Informent's Name/Reletionship		T	19b. Mailing Addre	ess (Street				Stete, Zip (Code)
		Margaret D. Usil	ton (Daugh				s Lane -	Worton	, MD 21	678	
once.	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Removel from State		e of Disposition (A etery, cremetory o			Dete	20c. Location -	City or Tow	vn, Stete
		4 ☐ Donation 5 ☐ Other (Spec	cify)	Sunny	vridge Memo			12/6/00	Crisfi	eld,	MD
OUCE		21 Signature of Punguri Service Lio Robert H. Br	Hadskou	1	Brade	end Addre	& Sons F	uneral		0101	
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State of Maryland /	Department of Health	and Mental Hygiene
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Funeral Director		Social Security Num	ber	S. Sex	7. Age (i	In yrs. lest birthday) Yrs.	Months Days	Hours Min	. (Month, D	irth ley, Year)	9. Bii	hthplece (State or Foreign ountry) ryland
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72 hours	-		5. Decedent's	Education grade completed	()	16a. Dece	dent's Usual Occup	etion during most of we	orkina	18b. Kin	d of Business	s/Industry
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2 shou and M la mar		19a. Informant's Name	e/Reletionshi	p (Type, Print)		19b. Maili	ing Address (Street	and Number or P	Rurel Route Num	ber, City or	Town, State.	Zip Code)
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Depar Impoi		21. Signature of Fune		ede, Dir	ector		2. Name and Addre		_		imore	MD 21201
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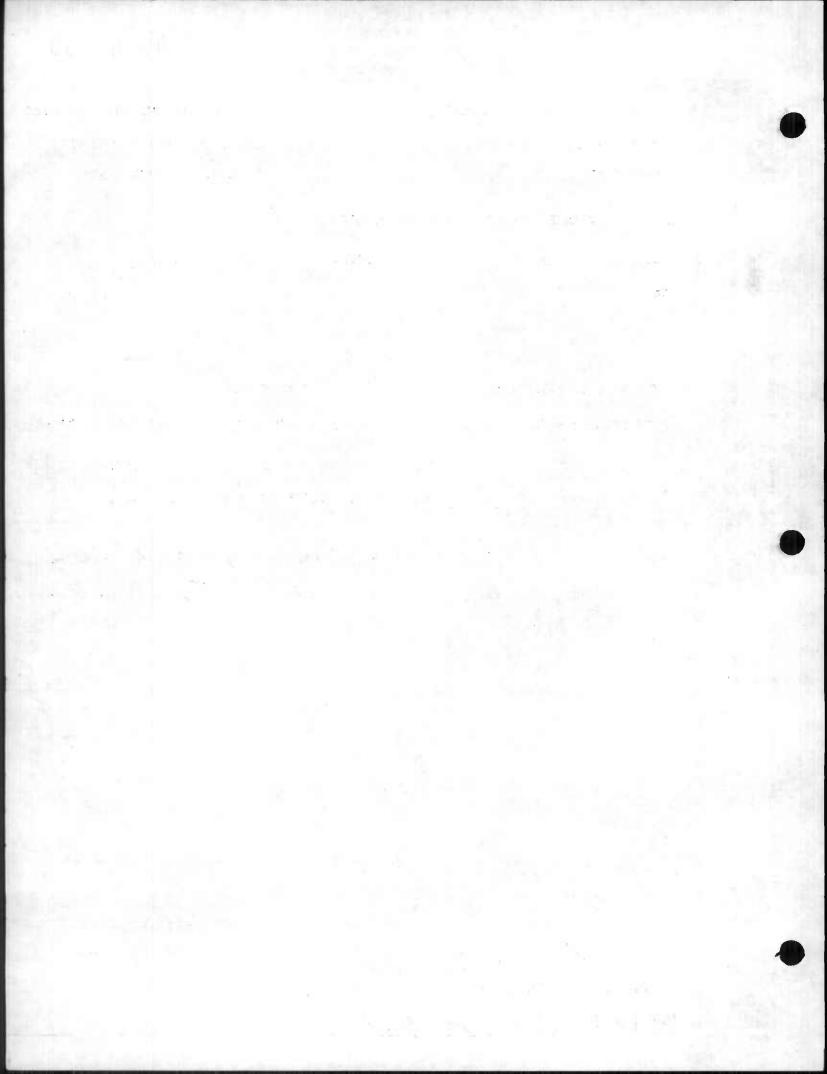
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Physician DECEMBER 30,2000 HENRY VAN AMBERG BIELSTEIN 11:03PM /Medical 4b. City. Town. or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner FORT WASHINGTON HOSPITAL FORT WASHINGTON PRINCE GEORGES It Under 1 Year 5. Social Security Number . Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys 10 M 2□ F Yrs. Director 279-30-4330 66 AUG. 23, 1934 OHIO Usual Residence of Deceden with the Meryland 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be notined at 1 ☐ Yes 2 ☐ No Directo MARYLAND PRINCE GEORGES FORT WASHINGTON 10f. Zip Code 10e. Street and Number 10a. Citizen of Whet Country? 20744 U.S.A. Funeral death 13425 REID CIRCLE 12. Wes Decedent Ever In U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, 11. Merital Status Black, White, etc. 72 hours after Never Merried 2 Merried Yes 2 No 1 Yes 2 No Specify: Specify: WHITE P 3 ☐ Widowed 4 ☐ Divorced 1981 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry nd Mental Hygiena. marked other than Etementery/Secondary (0-12) College (1-4or 5+) PHYSICIAN MEDICAL aith end Mental Hw 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 end 2 should be ment of Health end Menta ant: If itam 27 la marked lury or other traumatic av CLYDE WILLIAM BIELSTEIN VIOLET MADELINE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) JOHN BIELSTEIN (COUSIN) 12321 HATTON POINT ROAD, FT. WASHINGTON MD 20744 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete permit. Page Department of Important: If any injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) ARLINGTON NATIONAL CEMETERY 1/19/01 ARLINGTON, VA 22. Name end Address of Facility DEMAINE FUNERAL HOME 21. Signature of Funerel Service Licanses 520 S. WASHINGTON STREET ALEXANDRIA, Xe 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. ma Approximate Interval Between Onset and Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical ardra Examiner Due to (or es e conseguenca of) Examine certificate be executed physician end s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequenca ot): Physician/Medical Due to (or es a consequenca of): 980 ò ed by the a 23b. Did tobacco use contribute to the cause of death? Pert It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Onknown signed to Division of Vital Records, þ requires should t 24b. Wera autopsy tindings eveilable prior to 24a. Was an autopsy performed? Completed completion of cause of death? has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Wes case reterred to medical axaminer? Be 26. Place of Death (Check only one) Hospitel: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 1 funeral 28a. Date of trijury (Month, Dey Year) 27 Manner of Death 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Certification: Affier Attending 1XXNetural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, tectory, office building, etc. (Specify) 4 Homicide 8 24 hours 17. Cardlying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
21.3 modest Examiner: On the basis of examination and/or investigation in a propriate of the cause (s) and manner as stated. edical 29a. Certifie (Check only er: On the basts of exemination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. oneil To the 7 To the 9 complet 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) te of certifie 045 JANUARY 8, 2001 30. Name and address of person who com ted cause of deeth (Item 23a) (Type, Print) ARASTOO YAZDANI. M.D. 9801 GEORGIA AVENUE SILVER SPRING, MD 20902

State Registra

31. Date filed /Month. Day. Year)

DHMH 16 Rev 6/95

32. Registrer's Signeture parket ORIGINAL



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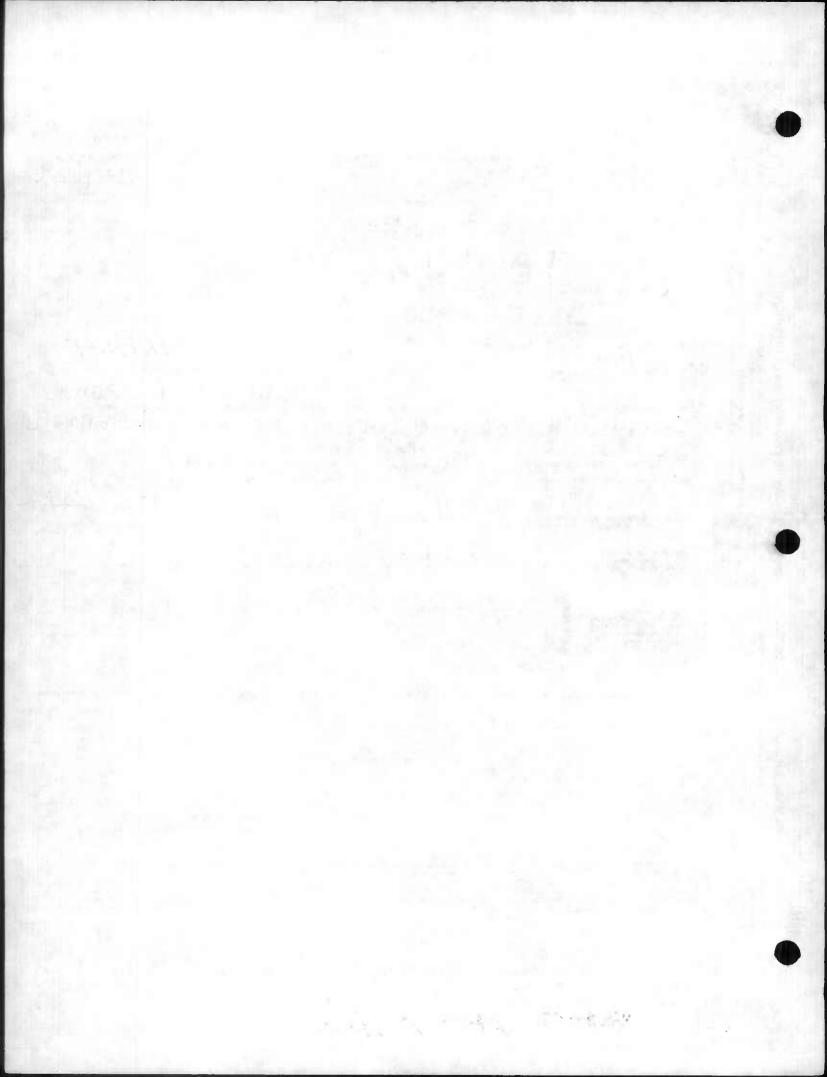
State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Day 12 Th **Physician** 0200 BABY BOY ALSTON CCTOBER 2000 /Medical 4a Facility Nama (If not Institution, give street and number)
ST AGNES HOSPIT 4b. City, Town, or Location of Death 4c, County of Death Examiner Baltimore AGNES HOSPITAL BALTIMORE If Undar 1 Yeer If Undar 24 Hrs. 8. Dete of Birth Mooth, Day, Year) 6. Sex 1 M 2□ F 9. Birthplace (Stata or Foraign Mary (and 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Yrs. Director Usual Rasidence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Nas 2 No MD Baltimore Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 1 23a or 2 Drive A2Upermit. Pagas 1 and 2 should be filed within 72 hours after death v. Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than "natural", or itema 23a and highery or other traumatic event, the Heddel Expriner must page. Funeral 12. Was Decedent Evar in U,S Armed Forces? 1 ☐ Yas 2 M No If Yas, Giva Yaar or Datas: 14. Race - American Indien, Black, Whita, atc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 Navar Married 2 Merried Baltimore, Maryland 21215-0020 1 Yas 20 No Black Specify. Specify: by 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) Collaga (1-4or 5+) A 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Joshette 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Toyug, State, Zip Code) Balto Hd 21216 Drive Way Josnette D. Alston Mother 20b. Place of Disposition (Nema of cematery, cramatory or other place) 20c Cocation - City or Town, Stata 20a. Mathod of Disposition Data 1 Burial 2 Cremation 3 Ramoval from Stata
4 Donetion 5 Othar (Specify) -06.20d 21. Signature of Funaral Sarvice Licenses Ha Health care Certon 900 aque 0 23a. Pent1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause of each line. Approximata Intarval Batween Onset end Death **Physician** Immediata Causa (Final disaasa or condition resulting in deeth) /Medical EXTREME PREMATURIT Examiner Physician/Medical Examiner Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Diseasa or Injury that initiated evants rasulting in death) Last Box 68760, Due to (or as a consequence of) P.0. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, by The law requires 24b. Wara autopsy findings available prior to complation of causa of deeth? 24a. Was an eutopsy performed? Be Completed 1 Yas 2 No 1 Yes 2□ No 25. Was casa rafarred to medical 26. Placa of Death (Check only one) Hospitel: 1 nestient 2 ER/Outpetient 3 DOA Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 ☐ Yas 2 No edical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred i or Attending F 5 Pending invastigation NA 1 Yas 2 No NA 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, streat, fectory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 29a Certifier 1 Certifying Physician: To the best of my knowledga, daeth occurred et tha tima, data and place, and dua to the ceuse(s) end mennar es stated.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at tha time, data end place, and dua to tha ceusa(s) and mannar statad. 29d. Deta signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. Licensa number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael P. Parsons St Qanes H ealth Care. 900 S. Caton Ave. St agnes 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

State Registrar

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2001

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month -WKE Garner **Physician** orian 1100 pm 2000 0 /Medical 4a Facility Name (If not institution, give street and number)
St. Joseph's Med 4b. City, Town, or Location of Death 4c. County of Death Examiner JOWSON Baltimore 8. Sex 1 M 2 □ F If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days NIA Director 10-19-2000 30 MARYLAND Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, tra Modical Examinar mant be notified at 1 ☐ Yes 2 No Director MARYland Cockeysville BAltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SigRid ROAD USA 8822 21133 death Funeral 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health end Mental Hygiene. Important: If item 27 is marked other than "naturel", or frem any injury or other traumetic event, the Mental on the page. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Şecondary (0-12) College (1-4or 5+) NA NA NA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) LA mont GARNER DARRYI ANGELA (UNKNOWN MAIDEN 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Redeemer Cemetery BAltiMORE City, MARY/AND 22. Name and Address of Facility 21. Signature of Funeral Service Licansee Towson, md. St. Joseph Medical Center 7601 Osler Dr. 21204 234 Fapt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, or heart failure. List only poe cause on each line. Approximate Interval Between Onset and Death **Physician** Medical immediate Ceuse (Final Prematurity disease or condition resulting in death) Examiner Examiner rdio Pulmonary physician and the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or as a consequence of): ed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t d be detech 1 Yes 2 No 3 Probably 4 Unknown ģ been si 24b. Were eutopsy findings available prior fo Completed 24e. Was en eutopsy performed? completion of cause of death? s certificate has b director, page 2 s 1 ☐ Yes 2 No 1 Yes 2□ No director. or Attending Physician: efter death. 25. Wes case referred to medical 86 26. Plece of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral 28e. Date of Injury (Month, Day Year) Certification: 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred MA 1 Neturel 5 Pending 1 Tyes 2 No Investigation NA NA NA 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - Af home, farm, sfreef, fectory, offica building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homlcide • Funerei Di e Funerei Di NA 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) within 2 To the 29b. Signature and title of cartifier 29c. License number 29d. Dete signed (Month, Day, Year) n 44809 10.19.00 MY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)____ St. To seph hospital Town mo MOHAMME 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State MAR 2 6 2001 Registrar

DHMH 16 Rev 6/95

Secretary 1920 1920

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Year Month 5:36 AM CAMPIA ALAYSIA BOONE DEC. 10 2000 4e Facility Nama (If not institution, give effect and number) 4b. City, Town, or Location of Death 4c. County of Death PLINCE GEORGES HUSPITAL CENTER CHEVERUY PRINCE GEORGES Hunder 24 Hrs. 8: Data of Birth (Month, Day, Year) If Under 1 Year 6. Sex 7. Aga (In yrs. last birthdey) Birthplace (State or Foreign Country) Months Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits MARYLAND PRINCE GEORGES RIVERDALE 1 Yes 2 No 10a. Street and Number 10f Zin Code 10g. Citizen of What Country? 5621 - 61 ST PLACE 20737 U.S.A. 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 11 Meritel Status Bleck, Whita, etc. 1 ☐ Yes 2 ☒ No If Yes, Giva Navar Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) NONE - INFANT NONE - INFANT ione work 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) BRANDY MAISHA CORTRELL WILLIAM THOMPSON BOONE 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 5621-615T PLACE RIVERDALE MD 20737 BRANDY M. BOONE, MOTHER 20c Location - City or Town, Stete 20b. Plece of Disposition (Neme of cematery cremetory or other p 20a. Method of Disposition 1 Burial 2 Cremation 3 Removel from State
4 Donetion 5 Double 1 or other piece) 22. Name and Address of Facility enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest or heart failure. List only one cause on each line. Approximete Intervel Between Onsat and Death Immediate Cause (Final EXTREME Prematurily disease or condition resulting in deeth) Dua to (or es e consequence of): Respiratory distuess Due to (or es e consequence of): Pulmonary he
Due to (or es e consequenca of): hemorrhage Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 22 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? completion of causa of death? 1 ☐ Yas 2 XNo 1 Yas 2 No

Physician /Medical Examiner

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attending physician

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To the Hospital of within 24 hours of To the Funeral Dicompletely filled in

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P.O. Box 68760

Division of Vital Records,

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Physician

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Funeral

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25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred

28a. Dete of Injury (Month, Dey Year) 28c. Injury of Work? 1 Neturel 5 Pending 1 Yes 2 No Investigation 2 Accident

6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

12 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) end menner stefed. 29e. Certifier

29b. Signeture and title of cartifier 29c. Licensa number 29d. Date signed (Month, Day, Year)

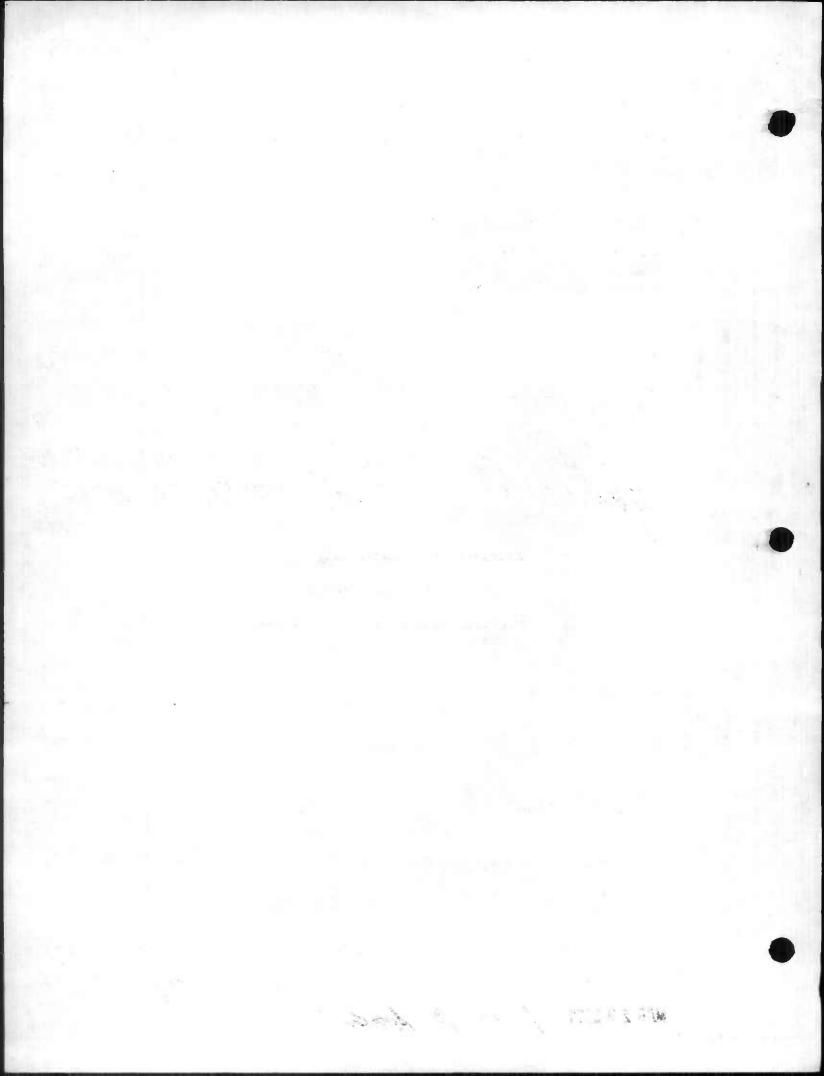
mennella Abroom MARCH 26, 2001 D0088189

30. Name end address of person who completed cause of death (Item 23a) (Type, Print) ABEDIN 3001 HOSPITAL DRIVE, CHEVERLY, MO 20785 HEHNUR

Registrar

31. Dafa filed (Month, Dey, Year) MAR 2 9 2001

32. Registrar's Signature

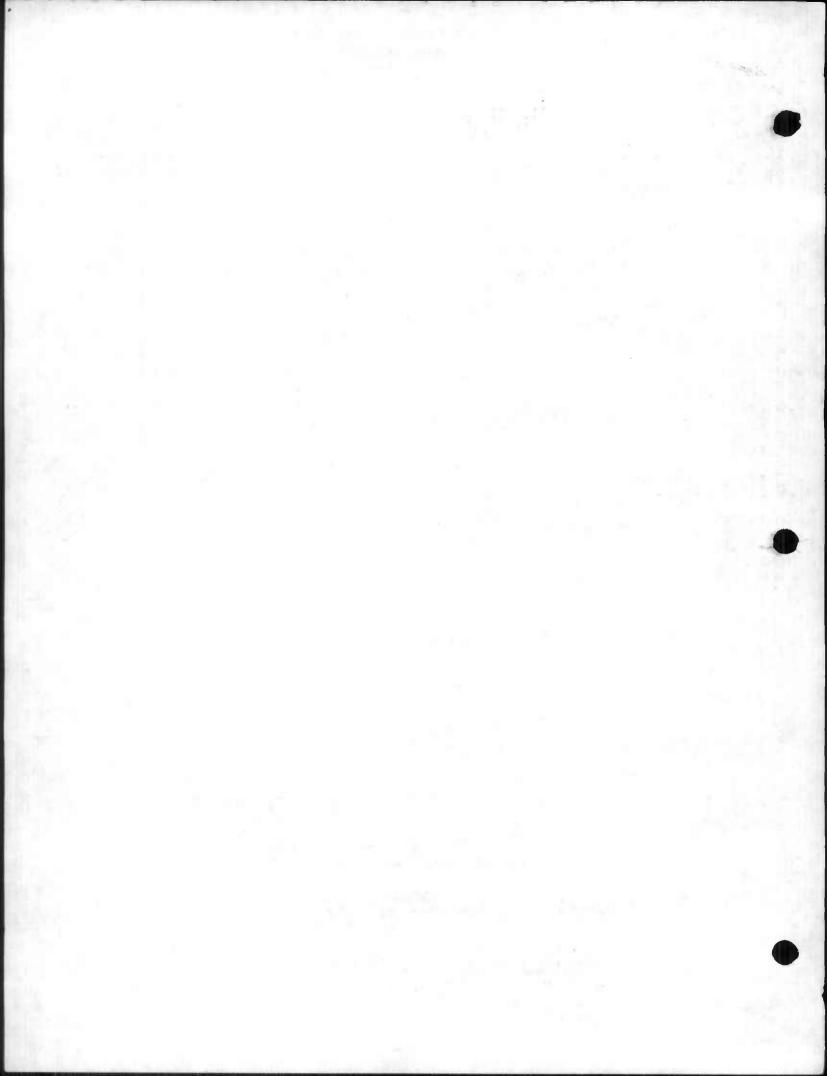


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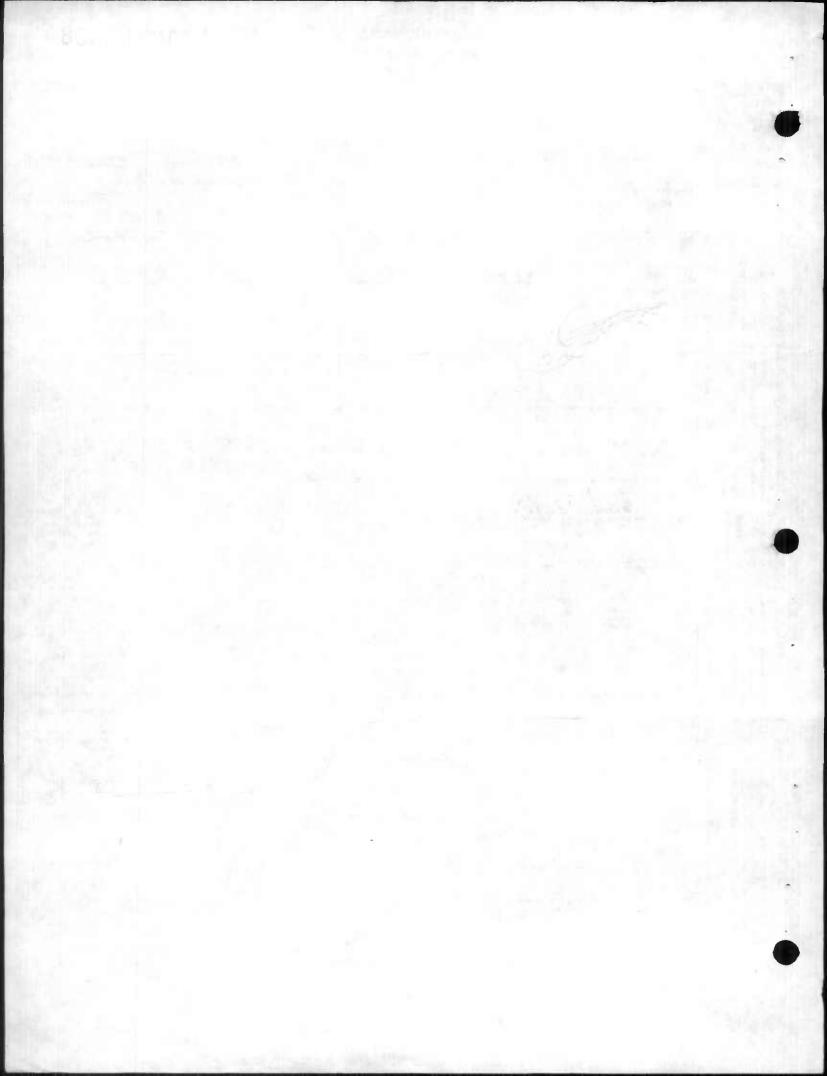
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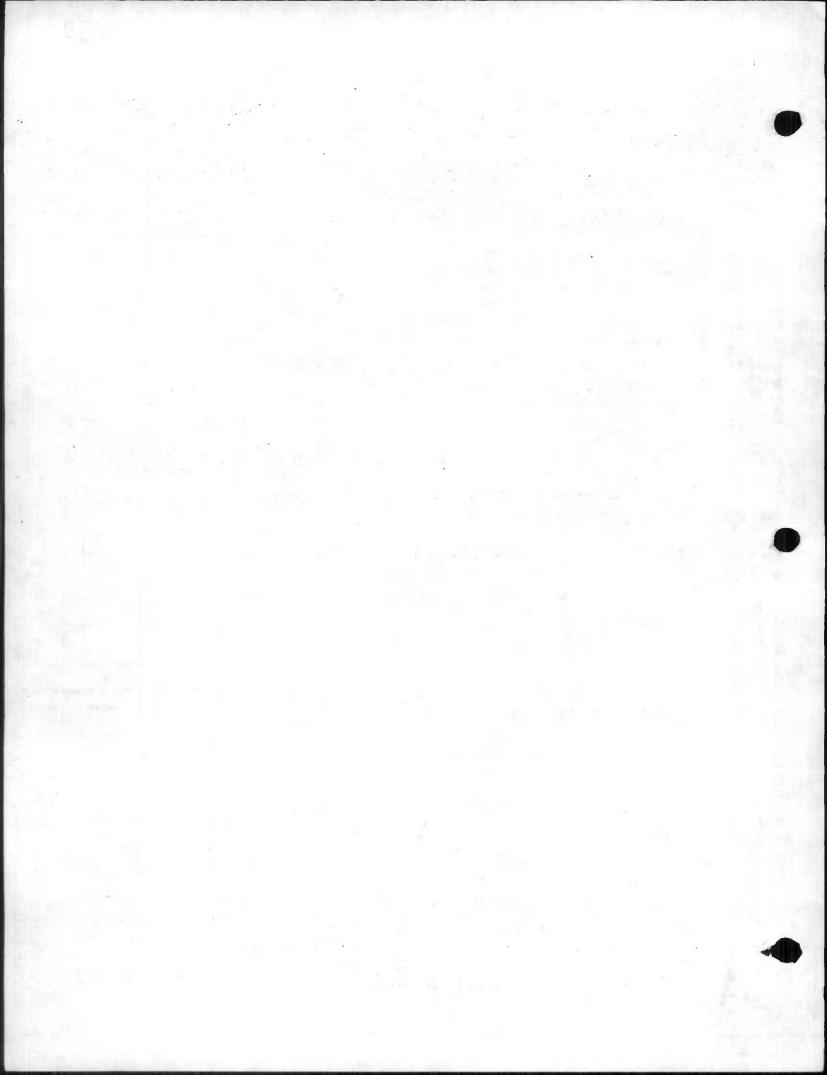
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State of Maryland / Department of Health and Mental Hygiene

RECREATED Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day **Physician** 2000 11:00am 411 16 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Meadows rement Community If Under 1 Yaar If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) STreet, MD **Funeral** 15-34-Days Months Hours 0302 1□M 20 F Director Usual Residence of Decedent Merylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Director or the 10f Zin Code 10e Street and Number 10g. Citizen of What Country? "natural", or items 23s or 12: 21154 Koaa Funeral 14. Race - American India Black, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Health and Mentel Hygiene. Introcramt: if Nem 27 is marked other than "natural", or hen eny injury or other treumatic event, the Medical Pages. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify. If Yas, Giva Year or Dates: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ 17. Father's Nama (First Mickille Last) 18. Mother's Nama (First, Middle, Maiden Surnama) 8 Henry grass Alvania 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 20b. Place of Disposition (Nama of 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata matory or other place 1⊠Burial 2 ☐ Cremation 3 ☐ Removal from State ana 4 ☐ Donation 5 ☐ Other (Specify) Cemmin 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Jeffrey Lovelidge per DVR uneral Home, inst 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final MIZHEIMER disease or condition resulting in death) Examiner Dua to (or as a consequence of) Examiner physician end s the buriel-trans Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Division of VItal Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yea 2006 3 Probably 4 Unknown 2 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? pege 2 2000 1 Yas 1 Yes 2 No certificate or Attending Physicien: 25. Was casa refarred to medical examiner? director. 8 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Usursing Homa 5 Residence 8 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA thie 27. Manger of Death 1 Watural 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 5 Pending efter deeth. Director: Aft 1 Yas 2 No invastigation 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) in by 4 Homicide within 24 hours eft To the Funeral Di completely filled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a, Certifier To the 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number cause of death (Item 23a) (Type, Print) person who completed PALTIMORES MD 21204 CABM 6 N CHARLUTS no 2 1 2000 strar's Signatura State oorks Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 4 3 6 6 0 State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Physician Baby Girl Maduro 4b. City, Town, or Location of Deeth 2000 /Medical 1120 4e. Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner Hospital Munder 1 Year Shady Grove Adventist 5. Social Security Number 6. Sex 7. Age Rockville Mc
r | ft Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) Montgomery 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Months Deys 1 M 2 F **Director** Unknown/Pork 9 39 May 2, 2000 Usuel Residence of Decedent with the Maryland 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be nothed at 1 ☐ Yes 2 ☐ No Directo Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? permit. Pegas 1 end 2 should be filed within 72 hours after death w Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natura" once. 11413 Viers Mill Road 20902 Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 1 Never Merried 2 Merried 1 Yes 2□ No by Specify: Hispanic 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None None None 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Luis Madura 2 Ana Madura 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 11413 Viers Mill Rd MO Wheaton Luis + Ana 20e. Method of Disposition 22. Name and Address of Facility Shady Crove Adventist Hospital 21. Signature of Funeral Service Licensee 9901 Modical Center Dr. Rockville MD 20850 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse Finel diseese or condition resulting in death EXTREME PREMATURITY 30 hours Examiner RESPIRATORY DISTRESS SYNDROME
Auto (or es e consequence of): 30 hours Examiner or Attending Physician: The law requires that the death certificate be axecuted Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury 30 hours DAGULOPATHY Box 68760, attending physician for use as the burie Physician/Medical thet initieted events resulting in deeth) Lest Due to (or es e consequence of): 30 hours JEPS 15 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24e. Was en eutopsy performed? Completed 2 No certificata 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medicel examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Minpatient 2 ER/Outpetient 3 DOA this 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Naturei 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital 29a. Certifier Medical 1 Cartifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end pieca, end due to the ceuse(s) end menner es stated. (Check only one) 2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, deeth occurred et the time, dete and piece, and due to the cause(s) end manner steted. within 2 29c. License number 3 29b. Signeture and thie of cartifier 29d. Dete signed (Month, Day, Year) Mayor MB April 2, 2001 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Center Dr. Rockville, MD 20850 31. Dete filed (Month, Dey, Year)
APR 2 4 2001 32. Registrer's Signeture State Registrar

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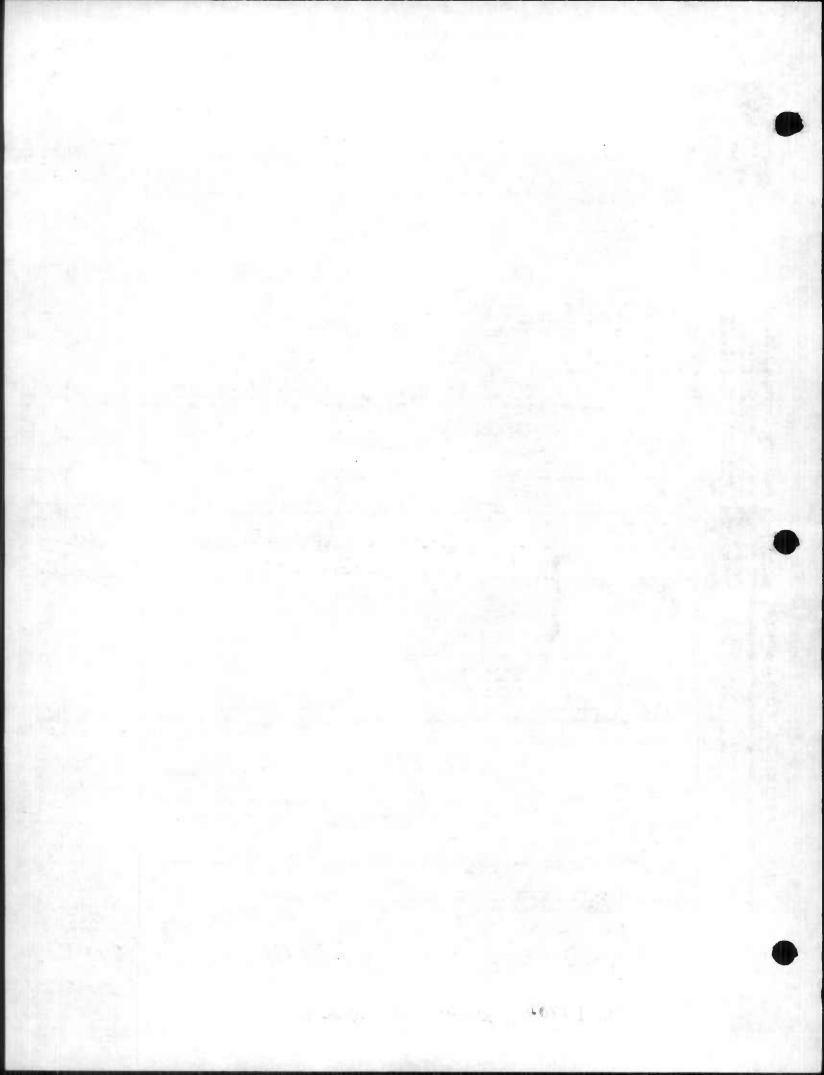
State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month Physician E. Williamson December 8, 2000 1440 James /Medical 4a. Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Daath Examiner Anne Arundel Medical Center Annapolis Anne Arundel H Undar 1 Yaar If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Sacurity Number Birthplace (State or Foreign Country) 7. Aga (In yrs. lest birthdey) **Funeral** Months Deys 1(XM 2□ F Yrs. March 26, 1946 **Director** 216-44-6319 Maryland Usual Rasidance of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits rail, or itema 23a or 28a-f ahow Examiner must be notified at 1 Yas 2 No Directo Maryland Anne Arundel Severna Park 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code 866 B & A 21146 USA Funeral 12. Was Decedent Evar in U.S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 11. Maritat Status 72 hours after 1 ☐ Yas 2 ☒ No tf Yes, Giva Yaar or Dates: 1 Nevar Married 2 Married "natural", or 1 Yas 2 No Specify: Black. þ 3 ☐ Widowed 4 ☐ Divorced Completed the Madical 15. Decedant's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Collega (1-4or 5+) Elementary/Secondary (0-12) Laborer Party Rentals 11th peli Hygin 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surneme) Be should be is marked Robert Williamson Emma Hunt. 2 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Peges 1 end 2 sh Department of Heelth and Important: If Item 27 is n any injury or other traun Mary M. Williamson, Wife 866 B & A Blvd., Severna Park, MD 21146 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Ramovel from Stata
4 Donation 5 Other (Specify) Annapolis Mem. Gardens 12/14/2000 Annapolis, MD 21. Signature of Funeral Sarvice Licensaa 22. Name and Addrass of Facility 821 West St., Annapolis, MD Larry G. Reese, MOO483 WM. Reese & Sons Mortuary, P.A. 21401 23a. Pert1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batwaan Onset end Death Immediata Causa (Final disease or condition rasulting in death) **Physician** /Medical Dua to (or as a co sequenca of): Examiner Leussoy Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disaasa or Injury that initiated evants resulting in daath) Last Dua to (or as e cons Examiner nce of): death certificate be executed burial-tran the attending physician and Due to (or as a consequence of): Physician/Medical as the IF FEMALE: 950 23c. If yes, outcome of pregnency

1 Liva birth 2 Fetal daath

4 Pregnent at time of death 23d. Data of dativary 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ŏ in the pest 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown detached 9 Unknown been signed by Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contributa to the causa of death? þ Records, requires page 2 should be 4 Sonknown 1 Yas 2 No 3 Probably Completed 24b. Wara eutopsy findings available prior to completion of causa of daath? aw 24e. Was en this certificate has The 1 Yas Yes 2 No Physician: 25. Was case referred to medical Be 26. Placa of Daath (Check only one) axaminer? Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) 1 Yas Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA funeral dir 27. Mannar of Daath 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred ai or Attanding P i after death. i Diractor: After t d in by the funera 1 Netural 2 Accidant 5 Panding Injury 1 Yas 2 No investigation 6 Could not be datermined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida To the Hospital within 24 hours at To the Funeral D 29a. Certifiar Certifying Physician: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(s) and menner as steted.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. Medical (Check only one) 29b. Signatur and title of certifier 29c. Licensa number 29d. Data signad (Month, Day, Yeer) 30. Name and addless of berson who complated cause of death (Item 23a) (Typa, Print) DAVIS ANNE HRUNDEZ TUNG . Date fited (Month 32. Registrar's Signatura State Registrar



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Examin	ner		o (# not institution, gr out Ordere	re street and number) d		4	Rockv	ille	of Death			. County of Dec	ry County
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21215-0036 od within 72 hours atter glens. ar then "netural", or its ar the Medical Examins	Completed		15. Decedent's E pecify only highest gr econdary (0-12)	ducation			t's Usual Oc d of work do NOT use rel	cupation ne during mos lired)	st of working		158	Cind of Busines	
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Baltimore, permit. Peges 1 al Department of Hes Important: if Itam any Injury or othe			Funeral Service Lice	yCourt ord	iered	22. N	ame and Ad	dress of Fecil	ity				
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DIVISIO To the Hospital or Attendi within 24 hours stier death. To the Funarel Director: A	Certification;	3 Suicide	de determined	building, e						City or T	own, Stat	e)	Rural Route Number,
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Physici /Medic Examir

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Menyland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Evantmer must be notified at each.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be delached for use as the burial-trans

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Piease Type or Print in Black Indelible Ink. Assure Aii Copies Are Legible.

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4a Facility Nema (II n 811 ROL)	ot Institution,	give street and n	number)		-15		4	BALT		ocation of Deeth	1 40		of Death	0.10	***
5. Social Security Num 217-62-36	04	5. Sex 1 □ M 2√2 F		(In yrs. las	ot birthday) Yrs.	If Under Months	1 Yeer Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da AUG • 24	th y, Year,	954		place (State of http:// yland	r Foreig
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31. Data filed (Month, Day, Year)
MAR 2 2 2002 State Registrar

Fowler 32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

Registrar **DHMH 16 Rev 6/95**

State

29b. Signature and title of pertilier

31. Date filed (Month, Day, Year)

JUN 0 9 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signeture

on second

29c. License number

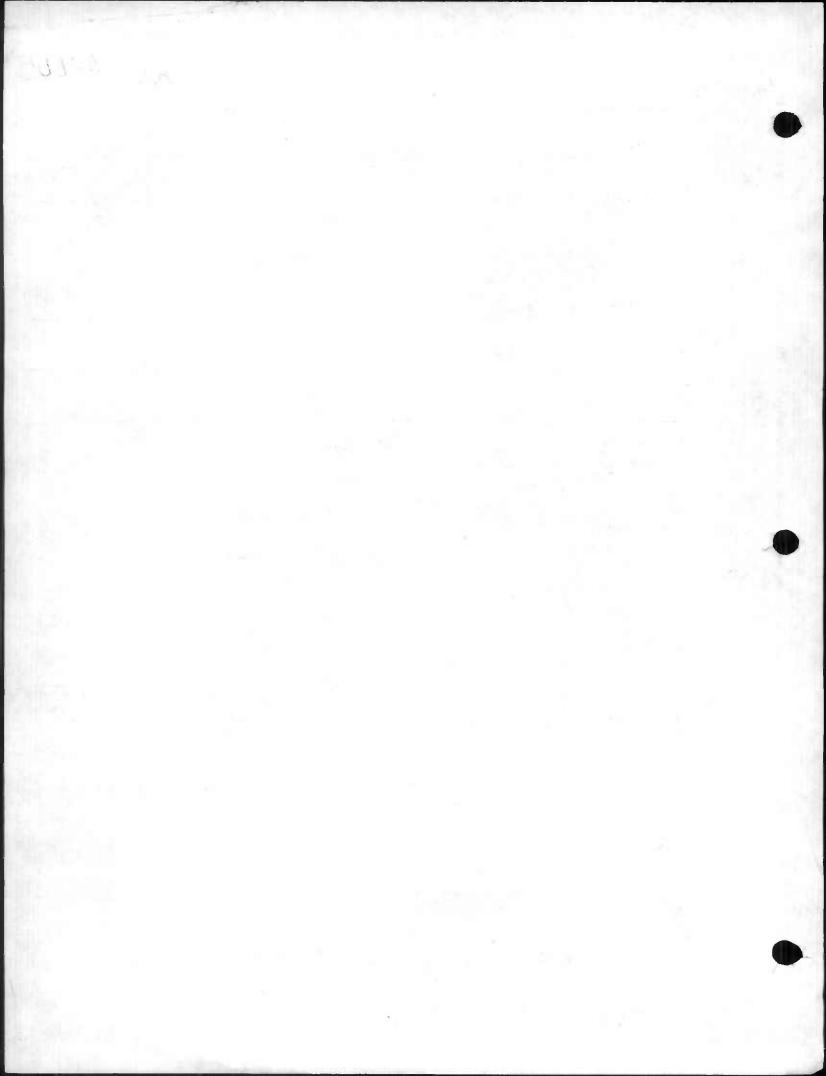
O.C.M.E

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

AUG.

5, 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

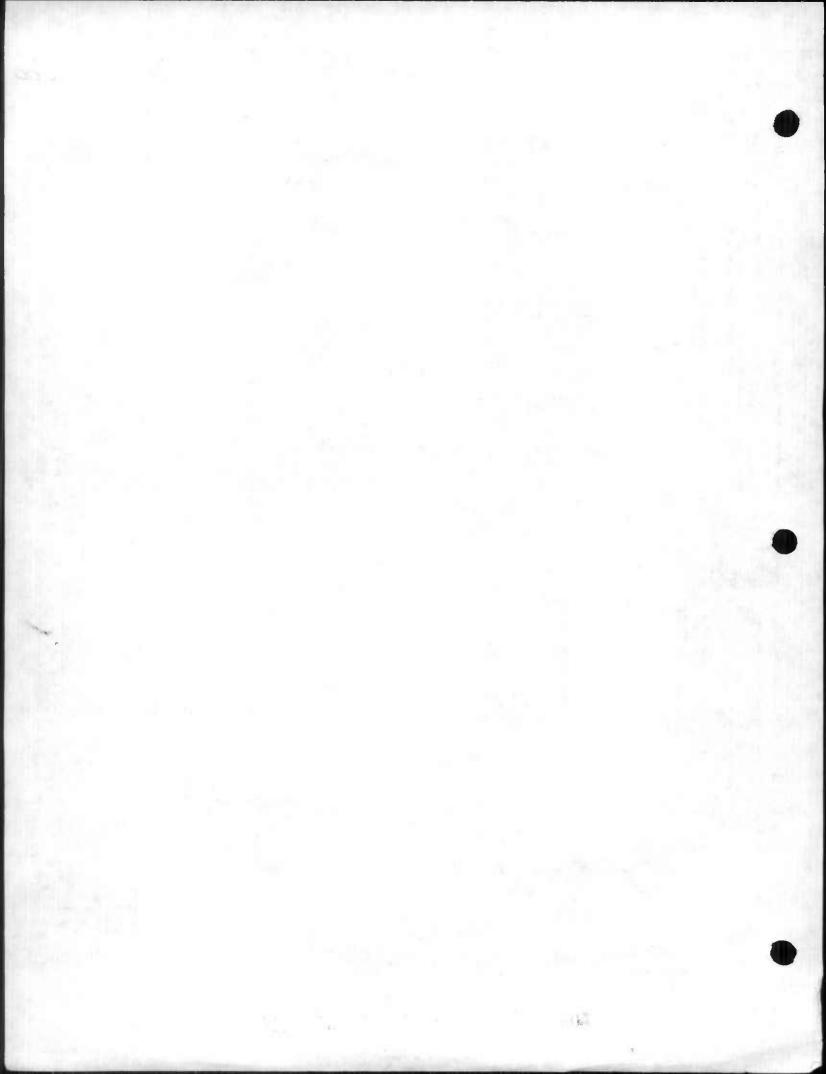
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			Certificate o	f Death	В	eg. No 20	X) -1	4366
Oleve in in	Decedent's Name (First, Middle, Last)				2. Date of Deel		Veer	3. Time ot Death
Physician /Medical	unknown 00-085				APRIL	13, 200	00	1850 PM
Examiner	4a Facility Neme (# not institution, give street	t end number)		4b. City, Town, or L	ocation of Death	4c. County of	of Deeth	
Funeral Director	BEAVER DAM CREEK S 5. Social Security Number unk 6. Sex 1 M M	7. Age (In yrs. last	1 24 5 5 7 7 7 7 7 7 7 7		8. Date of Birth (Month, Dey			GES COUN se (State or Foreig unk
_	Usuet Residence of Decedent	GIII						
how How	10a. Stete 10b. County		own or Location				10d.	. Inside City Limit
To to	MD Prince Geo	rge's Be	ltsville					1 ☐ Yes 2 🖾 N
/z nours arrer deam wint the maryend natural', or items 23a or 23a-1 show sical Examinat mark be noured at sted by Funeral Director	10e. Street end Number UNK		10f. Zip Code		unk	0g. Citizen of W USA		?
r items 23		as Decedent Ever in U.S.		f Hispanic Origin? (Spuban, Mexican, Puerto	pecify Yes or No-		- American	
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than 'r	(Specify only highest grade con Elementery/Secondary (0-12)	college (1-4or 5+)	(Give kind of work dor life. DO NOT use ref.	ired)	(III)			
the M	unk unk							
nd Mental Hygiene. marked other than "natura imatic event, the Medical. To Be Completed	17. Father's Name (First, Middle, Last)	7	unk	18. Mother's Nen	ne (First, Middle, I	Maiden Sumeme	a)	unk
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# W F	O.C.M.E.		111 Penn St	reet Balti	more, MD	21201		
in it is	20a. Method of Disposition 1 □ Burial 2 □ Cremetion 3 □ Remore 4 □ Donetion 5 ☒ Other (Specify) 1.1	val from State	of Disposition (Neme of etery, cremetory or other p			20c. Location - (City or Town	n, Slate
Departmen important any injury otics	21. Sonature of Funeral Service Licenses Rona Ld S Wac	- 4 /		dress of Facility atomy Boar		Baltimo	ore St	reet
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hysician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in death) a	Ligature Strang Of The Head	gulation And Bli e consequence of):	unt Force In	juries		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
physicien and s the buriel-transit	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or es	e consequence of):					
0 4 5	thet initiated events resulting in deeth) Lest	Due to (or as	a consequence of):					
d by the attendir elached for use Physician/A	Pert II. Other significant conditions contribu	ting to death but not resultin	g in the underlying cause	given in Part I.	23b. Did to	obacco uae con	tribute to the	he cause of deat
00					1 U Y	es 2 No	3 Probal	bly 4 ☐ Unkno
2 shou					24a. Was a perfor		eveila	eutopsy finding able prior to pletion of cause eth?
s certificate he director, page					1XXY	es 2 No	1 🖾 1	Yes 2 No
certificate rector, pag	25. Was case referred to medicat			26. Plece of Dea	th (Check only or	10)		
this certific ral director. To Be	examiner? 1XX es 2 No Hospi	tal: 1 ☐ Inpatient 2 ☐ ER	Outpatient 3□ DOA	Other	ome 5 Resid		er (Specify)	AT SCENE
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tor: After the fune cation	investigation +	1 4 17 40 000	4.4	Yes 2 XNo	Subject	Strangled	And St	ruck
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within 24 hours after of To the Funeral Direct completely filled in by Medical Certiff	(Check only 2 XMedical Examiner:	n: To the best of my knowled on the basis of examination and manner steted.			, end due to the c	ause(s) end mai		
within To the comple	29b. Signature end title of certitier		29c, Lice	ense number	2	9d. Date signed	(Month. De	ov. Year)
× 50	Theodon Il	Vignus		OCME		APRIL 1		
	30. Name and address of person who compli							
	HEUPOLE MIKERS	111 F	Penn Street,	Baltimore	, Maryla	and 2120	1	
State	31. Dete tiled (Month, Day, Year)	32. Registrer's Signature			-			
Registrar	AUG 1/5	2003	nas 19	1. 11				

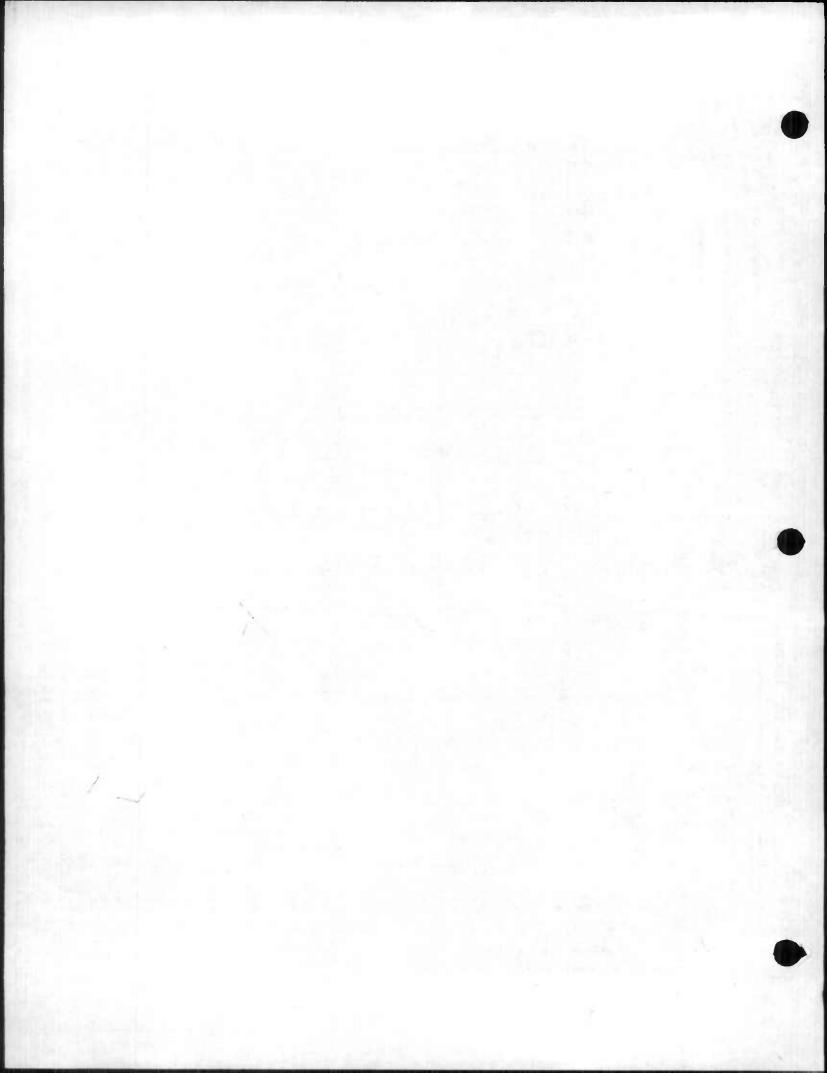
DHMH 16 Rev 6/95

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	R	leg. No. 2.000	-4366
Physician	1. Decedeni's Name (First, Middle, Last)	2. Daly of Dee Month		3. Time of Death
Adomost Exammer	JOHN HENRY MORRIS 4a Facility Name (if not institution, pive street and number) 4b. City. Town	or Location of Death	2,2000	0505
	DESTRUCTION A REPORT AND A PROPERTY OF THE PRO	SBURY	4c. County of Death WICOMI	
Funeral	5. Social Security Number 8. Sex 7. Age (In yrs. last birthday)	irs. 8. Date of Birth	Veer) U. Birth	place (State or Fore
Director	Usual Residence of Decedent	NOV. 25	, 1904 DEI	AWARE
1 19	10s, State 10b, County 10c, City, Town or Location			10d, Inaide City Limi
with the Hary or Me-Cate to method	MARYLAND SOMERSET PRINCESS ANNE			1 Yes \$
Direct Day	10s. Street and Number 10f. Zip Code	1	Og. Citizen of What Co.	ntry?
Funeral	10005 ARDEN STATION RD 21853 11. Mar/fel Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Managin Ordan?		U.S.A.	
	Armed Forces?	(Spealty Yea or No- erio Rican, etc.)	14. Race - Amer Black, White	can Indian, , etc.
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or the fraction	15. Decoders's Education (Specify andy highest grade completed) 16a. Decoders's Linual Occupation (Give kind of work done during most of a	orking	18b. Kind of Business/in	duttry
	Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR		TRANSIT CON	(T) 6 3 73 7
	A CONTRACT OF THE CONTRACT OF	lame (First, Middle, I		IPANI
165 b	JAMES MORRIS LYDIA	SHORT		
	10s. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or		City or Town, State, Zi	Code)
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2 2 2	1 Cl Burtal 2 Cramation 3 OFternoval from State carmatery, cramatory or other place)		20c. Location - City or T	
	4 Donatkun 5 Oother (Specify) WICOMICO MEMORIAL PARK	4/5/00 8	705 E. MAI	
SEES	DE TO ALL	AND The		
	23a Part . Enter the disease, or complications that called the death. Do not enter the mode of dying, such as card the	lore, INC.	SALISBURY	Approximals trilorval Between
wing physican and use as the butal-brank VM-edical Examin	Sequentially list conditions, if any, legiding to immediate cause. Enter Underlying Cause (Disease or injury that inhalited events resulting in death) Lust Due to (or as a consequence of):			
had for	Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did to	bacco use contribute t	o the cause of dea
to has been signed by the emmanage 2 should be detected for its completed by Physician	- meumorilis	101	10 2 No 3 Pro	bably 4 Unkni
bete bete		24a. Was ar	n autopsy 24b. W	era autopsy findings
2 N 0.			ec	aliable prior to impletion of cause death?
		1 🗆 Ye	8 2 No 11	Yes 20 No
director.	Housetet	eath (Check only on		
	27. Manner of Death 28e. Date of Injury 28b. Time of 28c. Injury at		nce 8 DOther (Special or injury occurred	. (4
in alter death. To Circotor: Alter ided in by the human Certification:	2 Accident Investigation M 1 Ves 2 No			
Sin by	3 Suicide 6 Could not be determined 28e. Ptece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str.	reel and Number or Run State)	I Raute Number,
	294. Cariffer 190 Cariffeing Provident To the heat of my householder double control in the line and all the			
n 24 hours piets by III	29a. Cariffer Check only (Check only (Chec	urred at the time, de	use(s) and manner as s its and pisos, and due to	tated. o the cause(x)
Tar Day	29b. Signature and title of certifier 29c. Liganse number		d. Date signed (Month)	Day, Year)
	* Kochy G. Wennels In D. D 1538	4	4141	00
ANC	30. Name and address of person the completed cause of death (flore 23s) (Type, Print)		- +++	
	RODWEYU A. VVENRICH 100 POWERS 31. Date filed (Month, Day, Year) APR 0 4 2000 32. Beginning & Sporks	T. SA	HLISBURY	M17 2190
State Registrar	APR 0 4 2000 32. Resistante Bionaruro S. Sports			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2000 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month **Physician** 4:00 PM 10 2000 4b. City, Town, or Location of Death Barbara Magdalene Smiles /Medical 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Franklin Square Hospital Center Rosedale Baltimore Birthplaca (State or Foreign Country) If Under 1 7. Age (In yrs. last birthday) 5. Social Security Number 8. Data of Birth (Month, Day, Year) **Funeral** 1 M XXF Yrs. Director 220-34-6124 98 Alabama Sept. 6,1901 Usual Residence of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Dir b Nerna 23s Elm Drive Funeral 21220 U.S.A.

14. Race - American Indian,
Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Merried 2 Married 1 ☐ Yes 2 ☒ No If Yas, Giva Yaar or Datas: 1 Yes 2 No Specify: Specify: 3 ₩ Widowed 4 Divorced White Barbara 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 3rd. Grade Homemaker Home 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Fred Frick Maggie Henn 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Eugene H. Smiles/ Son Octagon Avenue Sinking Spring PA 19608 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1X Burial 2 Cremetion 3 Ramoval from Stete 4 ☐ Donation 5 ☐ Othar (Specify) Elmwood Cemetery 1/17/2000 Birmingham 21. Signatura of Funarel Service Licensaa 22. Nama and Address of Facility John C. Miller, Inc. in 6415 Belair Road Baltimore 21206 23a. Part1. Enter the disease, or config. attons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. Lucroniv one cause on each line Approximata Intervel Between Onset and Death Physician Immediata Causa (Final disaasa or condition rasulting in death) /Medical . Exacerbation of Chronic Obstructive Pulmonary Disease 18 Days Examiner Examiner End Stage Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, laading to immadiata cause. Enter Undarlying Causa (Disease or injury that initieted avants rasulting in death) Last 68760 Physician/Medical Dua to (or as a consequence of): Box (P.0. Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t be del Urosepsis Records, 24b. Wera autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? 1 ☐ Yas 2 X No 1 Yes 2 No Division of Vital 25. Was casa rafarrad to medical axaminar? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA edical Certification: To this 27. Mannar of Death 28a. Deta of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Describe how injury occurred After Attending 5 Panding investigation 1 XNatural death. 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death Funeral Director: / 2 Accidant 3 Suicida 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Certifier \$ 29b. Signatura and title of certifiar 29c. License number 29d. Data signed (Month, Day, Year) January 10,2000 Tevera 30. Nama and addrass of person yand implated causa of death (Item 23a) (Type, Print) Marco A. Zamora MD 9000 Franklin Square Drive Baltimore, Maryland 21237 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State JAN 2 9 2007

DHMH 16 Rev 6/95

Registrar

1-24-07 - received from Miller Dippel 7 H(Mr) across the counter by Willards kwell

and the state of t

English Plant

Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate of	Death	Reg. No.	2000-430
Physician	1. Decadunt's Name (First, Middle, L.		~		2. Oals of Douth Month Day	Yest 3. Time of De
Micdical	Lovell	spencer,			Dec 12	2000 232
Examiner	48 Facility Name (If not institution, gi		a state	4b. Cly. Town, or L		unity of Detalh
		Sex 7. Age (in yrs. in.a)		MUNDAY 24 Hrs.		pr+1.
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22s or 25s-f show and be natified at all Director	10e. Stroot and Number		10l. Zip Coda		10g. Chizun	of What Country?
m 22 m	1015 MONROE ST	PEET	2140	3		S.A. Ruce - Anierican Indian,
r tem poer n Funer	11. minum Stiffs	12. Was Decedent Ever in U.S. Armed Ferous?	13. Was Ducadent of h	ilspanic Origin? (Spi an, Muxican, Puerlo	ncity Yes or No- Rican, etc.)	Ruce - American Indian, Black, White, etc.
- 2	10[Never Married 20 Married 30 Widowed 40 Diversed	1)0 Yes 2 No M Yas, Give Year or Dister: 1981 -	1 1 Yeu 3 000	Speally:	Sp	selly: BLACK
d by				-tlan		
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386 0	17. Fathor's Name (First, Middle, Last)		ASTER OPER		(First, Middle, Maldon Sun	ICA CORP
Memail artes ever To Be	LOVELL SPENC	CER SR.		ROSALE	E MYERS	•
Nem 27 is created other traversises	19u. Informent's Name/Reterioriship (1		b. Mailing Address (Street			wn, Slate, Zip Code)
2 T	LOVELL SPENCER,	SR. (FATHER)	1015 MONROR	ST. AN	NAPOLIS, MI	D. 21403
9 9	20s. Method of Disposition PD Burial 2 Coremation 3 C	20b. Piace	of Disposition (Name of	0)	Date 20s. Locatio	on - City or Yewn, State
fullen.	4 Donation 5 Other (Specify	MABY	LAND VETERA	N I	2/19/00 CR	DWNSVILLE, M
mportant: any fajury	21. Signature of Funeral Service Licen		22. Name and Addres	s of Facility		
2229	Lavy H.	Reese MO0483	WM REESE	& SONS	MORTUARY,	P.A.
4 1	23a. Part1. Enter the dilleges, or compensation, or heart fallers. List only of	Meations that caused the death. De	not under the modu of cylin	I such as cardiac o	APOLIS MD.	21401 Approximate Interval Balween
ysician	order, or river ramine. Car only t	wie cause oil such line,				Onset and Death
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ininer	disease or continion resulting in death)		convoquence of):	1/		YEAR
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1 4 E	Sequentially lies conditions, if any, leading to Immediate cause. Sinter Underlying Cause (Disease or injury that his lies ovente resulting in death) Last					i
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the state	Part II, Other aligniticant conditions co	Mribuiling to death but not resulting	in the underlying cause give	n in Part I.	23b. Did tobacco upe	contribute to the cause of des
imed by the by Phys					1 1 Yes 2 No	U Probably 40 Union
						1 an w
page 2 should Completed					24s. Was an eutopsy performed?	24b. Were autopay finding available prior to completion of cause of death?
Page 2		17				of death?
	26. Was case referred to medical				10 Yes 2100	1 🗆 Yea 2 🖸 No
	#EBruiner?	iospital: Discourse Comme		26. Place of Death /		
24	27. Manger of Death	1 Constient 2 DER/O	ADDRESS ATT DOY	4CJ Numing Hans	6 Maridance a DO	ther (Speally)
to the	1 Scherural 5 Panding Investigation		njury Work's	H 2 No	d. Describe how injury occur	тыд
Ne Funeral Director: Aber pletaly fised in by the funeral ectical Certification:	3 Suleido # Cauld not be	28s. Place of Injury - At home to		2010	I Locution (Street and 15	sbor or Rural Route Number
Sa T	4 C Homicide determined	28s. Pucy of-injury - At home, to building, etc. (Specify)	mrsq rectory, sales		City or Town, State)	or munar moute Number.
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7 F F F F F F F F F F F F F F F F F F F	(Check only 25 Checked Execution	ser; On the bests of examination an and manner stated.	d'or investigation, in my opin	ion, death occurred	at the time, date and place	, and due to the cause(s)
3 6 -	Sb. Signature and title of certifier		28c, License n	umbar	29d, Data sino	ed (Month, Day, Your)
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Aug. 28, 2007- preginal copy soiled @ ann arundul stearth whist. never received by x0.0. R. This is a copy. Simili sayor

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2000 -Certificate of Death 2. Date of Death 1. Decedant's Name (First, Middle, Last) Day Physician 2000 0745 DEC SAMUEL SIMMS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4s Facility Name (If not institution, give street and number) Examiner ANNAPOLI ARUNDEL ANNE ARUNDEL CENTER ANNE._ MEDICAL 8. Date of Birth (Month, Day, Year) 9. Birtholace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Daye **Funeral** 10 M 20 F Yrs. FEB. 16 1925 MARYLAND Director 7-24-7612 Usual Rasidence of Decedent pernit. Pages 1 and 2 should be Illed within 72 hours effer deeth with the Maryland. Department of Health and Mertal Hygiene. Important 8 fam 27 is marked other than "natural", or hens 23s or 23s-4 show any injury or other training event, the Medical Examples. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 1 Yea 2 □ No Director MARYLAND ANNE ARUNDEL ANNAPOLIS 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21403 USA Funeral 312 chesapeake Avenue 12. Was Decedont Ever in U.S. Armed Forces? 1 Yes 2 (2No If Yes, Givs 14. Race - American Indian. 13. Was Decadent of Hispania Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, ste 1 Never Married 20 Married 1 Yes 20 No Specify: Specify: BLACK Š 3 Widowed 4 Divorced Year or Dales Completed 16a, Decedent's Usual Occupetion (Give kind of work done during most of working life, DO NOT use relied) 16b. Kind of Business/Industry 16. Decadent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4ur 5+) FT. GEORGE MEADE BODY & FENDER. 12th 18. Mother's Nama (First, Middle, Malden Sumame) 17. Father's Neme (First, Middle, Last) Be ROSIE McCOY CHARLES H. SIMMS SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informeril's Name/Relationship (Type, Print) 312 CHESAPEAKE AVE. ANNAPOLIS, MD. 21403 LUCILLE SIMMS (WIFE) 20b. Place of Dispusition (Name of cernetery, crematory or other place) Dato 20a. Location - City or Town, State 204. Method of Disposition 15 Burlal 2 Cremetion 3 ERamoval from State ANNAPOLIS MEM. GARDENS 12/21/00 ANNAPOLIS, MD 4 Donation 5 Other (Specify) 22. Name and Addrass of Facility 21. Signature of Funeral Sarvice Licensee REESE & SONS MULTIUM.,

WEST ST., ANNAPOLIS MD. 21401
Approximate interval Between Onesel and Death & SONS MORTUARY, P.A. WM. REESE Keese myelowa Physician reave immodiate Cause (Final disease or condition resulting in death) /Medical Examiner Dua to (or as a consequence of) Exemine physician and 1 the burial-transit certificate be sosouled Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Injusted swents reculting in death) Lest Due to (or as a currequence of): Box 68760, edical Due to (or as a consequence of): Physician/M 23b. Did tobacco use contribute to the cause of death? Part it. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 KNo 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of bause of death? 24s, Was an autopsy performed? Completed Certificate has 1 Yes 1 Yes 2 No 2 NO To the Hospital or Attending Physician: within 24 hours inter deeth.
To the Funeral Director: After this cardical completely filled in by the funeral director. 26. Place of Daath (Check only one) 25. Wes case relatted to medical exeminer? 8 Huspital: Other: 4 Nursing Home 5 1 Residence 6 Other (Specify) 3) NOA 1 Yes 2 No 2 ER/Quipaliant 0 1 🗆 Inpation 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Menner of Death Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Acoldent 6 Could not be 28f. Location (Street and Number of Rural Route Number, City of Town, State) 3 Sulpido 28s. Piece of injury - Al home, farm, street, tactory, office building, etc. (Specify) 4 Il Iromioide the Certifying Physician: '(o the best of my knowledge, deem occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the osuse(s) and manner stated. 29a. Cartiller 8 (Check only 29d. Date algned (Month, Day, Year) 29b. Signafura and title of certifler 30 Name and address of person who completed cause of deeth (flem 23a), (Type, Pull), Selouide, M.D. TUQUE 32. Registrar's Signature 31: Data filed (Month, Day, Year) State DEC 1 8 2000 Registrar

DHMH 16 Rev 6/96

ORIGINAL

July 31,2009 Original Cert. file A.A. Co Never received by Vital Records

Randall & Snooks

00-4529-021 BKS Unknown 00-214 Rober

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	Stebbing 1. Decedent's Neme (Fi				06	partment of 96-10/02/ ertificate of	Dout		2. Date of Dec				e of Death
an	Robert G								Month August	Dey 12 2	Year 2000	4:3	7 PM
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C.	In Woods -	200 ya	rds fro	m Route	e 15		New	Thur	mont	Frede	erick		
	5. Social Security Numb	per 6. S	Sex M 2□F	7. Age (In yrs	. lest birthday	/) If Under 1 Year Months Day	r If Unde		8. Dete of Birt (Month, De			lace (Ste	ate or Foreign
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	3 ☐ Widowed 4 ☐		If Yes, Gr	Ve		1□ Yes 2□ N	Specify	r:		Specify	Whi	te	
Completed	15.	Decedent's E	ducation		16a. Dec	edent's Usuel Occ	upation			16b. Kind of Bu	usinass/Ind	dustry	
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State Registrar

31. Date filed (Month, Day, Year)

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32. Registrer's Signature